SOS
Multi.'
& Cit.
1988(2)
c.2

After the Door has been Opened

Mental Health Issues Affecting Immigrants and Refugees in Canada

Report
of the Canadian Task Force
on Mental Health Issues
Affecting Immigrants
and Refugees

Canadä

After the Door has been Opened

Mental Health Issues Affecting Immigrants and Refugees in Canada

BIBLIOTHÈQUE
SECRÉTARIAT D'ÉTAT DU CANADA
FEB 2 7 1989
LIBRARY
DEPARTMENT OF THE SECRETARY
OF STATE OF CANADA

Report
of the Canadian Task Force
on Mental Health Issues
Affecting Immigrants
and Refugees

1988

90-01557/

SoS

Canadian Cataloguing in Publication Data

Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees.

After the door has been opened: mental health issues affecting immigrants and refugees in Canada: report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees.

Also published in French under the title: Puis... la porte s'est ouverte.
Co-published by Health and Welfare Canada.
Bibliography: p.
ISBN: 0-662-16394-X

1. Immigrants — Mental health — Canada. 2. Immigrants — Mental health services — Canada. 3. Refugees — Mental health — Canada. 4. Refugees — Mental health services — Canada. 5. Mental health policy — Canada. I. Canada. Multiculturalism. II. Canada. Health and Welfare Canada. III. Title. IV. Title: Mental health issues affecting immigrants and refugees in Canada.

RC451.4.E45C36 1988 362.84 C88-099413-4

SoS
Multi.x
Co.t.
1988(2)
c.2

Contents

Letter of Transmittal
Task Force Members
Executive Summary

Part I: **Introduction** 1

Part II: **Prevention** 9

Chapter 1. Attitudes of Canadian Society 11
Chapter 2. Settlement and Social Support 15
Chapter 3. Official Language Education 23
Chapter 4. Employment 29

Part III: **Remedial Measures** 35

Chapter 5. Formal Mental Health Care 37
Chapter 6. Mental Health Care Outside the Formal Network 47
Chapter 7. Training for Service Providers 53
Chapter 8. Ethnic Practitioners 59

Part IV: **Special Needs** 63

Chapter 9. Children and Youth 65
Chapter 10. Women 73
Chapter 11. Seniors 79
Chapter 12. Victims of Catastrophic Stress 85

Part V: **Conclusions and Recommendations** 89

Appendices:

Appendix one *Glossary of Terms* 97
Appendix two *Written Submissions* 101
Appendix three *Oral Presentations* 105
Appendix four *Additional Consultations* 109
Appendix five *Works Cited* 111

Figures and Tables

Unless otherwise indicated, all figures are based on statistics provided by Employment and Immigration Canada. The Task Force wishes to acknowledge the helpful and generous assistance of this ministry.

Figure 0.1 Distribution of Immigrants by Immigration Class: Canada 1978–1987 4

Figure 0.2 Percentage of Canadian-Born and Foreign-Born in Total Population by Census Period: Canada 1861–1981 6

Figure 0.3 Regions of Origin by Year of Landing: Canada 1956–1986 7

Figure 2.1 Distribution of Immigrants 20 Years and Older by Marital Status: Canada 1978–1987 16

Table 2.1 Financial Support to Immigrant Services by Top Five Immigrant-Receiving Provinces: Canada 1986 20

Figure 3.1 Percentage of Male and Female Immigrants in Each Immigration Class Who Speak Neither Official Language: Canada 1978–1987 24

Figure 4.1 Years Education of Immigrants 25 Years and Older by Year of Landing: Canada 1978–1987 31

Figure 8.1 Distribution of Total Immigrants and Distribution of Immigrants in Selected Helping Professions by Region of Origin: Canada 1978–1987 60

Figure 9.1 Immigrants 0–19 Years of Age by Year of Landing: Canada 1978–1987 66

Figure 9.2 Distribution of Immigrants 0–19 Years of Age by Age Group and Class: Canada 1978–1987 67

Figure 10.1 Distribution of Classified Immigrants by Intended Occupation (Major Groups) and Sex: Canada 1978–1987 74

Figure 10.2 Percentage of Male and Female Immigrants in Adult Age Groups Who Speak Neither Official Language: Canada 1978–1987 75

Figure 11.1 Average Years Education of Male and Female Immigrants in Adult Age Groups: Canada 1978–1987 80

Figure 11.2 Percentage of Male and Female Immigrants in Adult Age Groups Who Are Unmarried: Canada 1978–1987 81

Table 12.1 Relative Utilization of Community Mental Health Services by Selected Ethno-Cultural Groups: Vancouver 1987 86

Figures and Tables

Unless otherwise indicated, all figures are based on statistics provided by Employment and Immigration Canada. The Task Force wishes to acknowledge the helpful and generous assistance of this ministry.

Figure 0.1 Distribution of Immigrants by Immigration Class: Canada 1978–1987 4

Figure 0.2 Percentage of Canadian-Born and Foreign-Born in Total Population by Census Period: Canada 1861–1981 6

Figure 0.3 Regions of Origin by Year of Landing: Canada 1956–1986 7

Figure 2.1 Distribution of Immigrants 20 Years and Older by Marital Status: Canada 1978–1987 16

Table 2.1 Financial Support to Immigrant Services by Top Five Immigrant-Receiving Provinces: Canada 1986 20

Figure 3.1 Percentage of Male and Female Immigrants in Each Immigration Class Who Speak Neither Official Language: Canada 1978–1987 24

Figure 4.1 Years Education of Immigrants 25 Years and Older by Year of Landing: Canada 1978–1987 31

Figure 8.1 Distribution of Total Immigrants and Distribution of Immigrants in Selected Helping Professions by Region of Origin: Canada 1978–1987 60

Figure 9.1 Immigrants 0–19 Years of Age by Year of Landing: Canada 1978–1987 66

Figure 9.2 Distribution of Immigrants 0–19 Years of Age by Age Group and Class: Canada 1978–1987 67

Figure 10.1 Distribution of Classified Immigrants by Intended Occupation (Major Groups) and Sex: Canada 1978–1987 74

Figure 10.2 Percentage of Male and Female Immigrants in Adult Age Groups Who Speak Neither Official Language: Canada 1978–1987 75

Figure 11.1 Average Years Education of Male and Female Immigrants in Adult Age Groups: Canada 1978–1987 80

Figure 11.2 Percentage of Male and Female Immigrants in Adult Age Groups Who Are Unmarried: Canada 1978–1987 81

Table 12.1 Relative Utilization of Community Mental Health Services by Selected Ethno-Cultural Groups: Vancouver 1987 86

CANADIAN TASK FORCE ON MENTAL HEALTH ISSUES AFFECTING IMMIGRANTS AND REFUGEES

The University of British Columbia
2255 Wesbrook Mall
Vancouver, B.C.
V6T 2A1
(604) 228-7340

May 1, 1988

The Honourable Gerry Weiner
Minister of State for Multiculturalism
House of Commons
Ottawa, Ontario

The Honourable Jake Epp
Minister of Health and Welfare
House of Commons
Ottawa, Ontario

Dear Ministers:

We are pleased to submit the report of the Task Force on Mental Health Issues Affecting Immigrants and Refugees.

As required by our terms of reference, we have examined and assessed the world research literature on this topic as well as unpublished reports by groups working in Canada; have received submissions, both oral and written, from service agencies, ethnic organizations and training institutions across Canada; and have made recommendations which will help to provide comprehensive, effective and sensitive approaches to meeting the needs of newcomers.

The Task Force acknowledges its gratitude to Dr. Merry Wood, Research Coordinator, for her invaluable assistance, and to Ms. Susan Johnston, Ms. Jeannine Hurd, the University of British Columbia Department of Psychiatry, and the Canadian Mental Health Association for providing support without which the project could not have been carried out. Perhaps most of all, we are grateful to the hundreds of individuals, agencies and organizations who shared their information and experience with us.

Canada continues to receive immigrants and refugees in order to meet national goals and because we are a humanitarian society. As a caring society, we must recognize that our responsibilities do not end when we open our doors to newcomers. The attached report describes how we can ensure the mental health of newcomers and thus enable them to become healthy, contributing members of Canadian society.

Sincerely,

Morton Beiser, M.D.
Chairperson

MB:spj

Sponsored by: Secretary of State-Multiculturalism and Health and Welfare Canada
in association with the Canadian Mental Health Association

Task Force Committee

Chair:

Morton Beiser, M.D.
Professor of Psychiatry
University of British Columbia
2255 Wesbrook Mall
Vancouver, British Columbia
V6T 2A1

Research Coordinator:

Merry Wood, Ph.D.
Research Coordinator
University of British Columbia
2255 Wesbrook Mall
Vancouver, British Columbia
V6T 2A1

Members:

Carmelina Barwick, B.Sc.N.
Senior Mental Health Consultant
Social and Community
Psychiatry Section
Clarke Institute of Psychiatry
250 College Street
Toronto, Ontario
M5T 1R8

John Berry, Ph.D.
Psychology Department
Queen's University
Humphrey Hall
Kingston, Ontario
K7L 3N6

Granville daCosta, M.D.
Child and Family Studies Centre
Clarke Institute of Psychiatry
250 College Street
Toronto, Ontario
M5T 1R8

Winifred Milne, M.S.W.
Director
Department of Social Work
Nova Scotia Hospital
P.O. Drawer 1004
Dartmouth, Nova Scotia
B2Y 3Z9

Anna Maria Fantino, M.Ed.
Immigration and Settlement
Services
Catholic Social Services
2nd Floor
10420, 107th Avenue
Edmonton, Alberta
T5H 0W1

Soma Ganesan, M.D.
Department of Psychiatry
University of British Columbia
2255 Wesbrook Mall
Vancouver, British Columbia
V6T 2A1

Christina Lee, Ed.D.
Ontario Women's Institute
2nd Floor
480 University Avenue
Toronto, Ontario
M5G 1V2

Michel Tousignant, Ph.D.
Directeur
Laboratoire de recherche
en écologie humaine et sociale
Université du Québec à Montréal
Montréal, Québec
H3C 3P8

Josephine Naidoo, Ph.D.
Department of Psychology
Wilfrid Laurier University
75 University Avenue West
Waterloo, Ontario
N2L 3C5

Raymond Prince, M.D.
Department of Psychiatry
McGill University
1033, Pine Avenue West
Montréal, Québec
H3A 1A1

Ernesto Vela, M.Sc.
Health Services Centre
Section of Behavioural Sciences
Department of Psychiatry
University of Manitoba
770 Bannatyne Avenue
Winnipeg, Manitoba
R3E 0W3

Executive Summary

Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees

The 12-member Task Force was established by Health and Welfare Canada and Secretary of State, Multiculturalism to identify factors influencing the mental health of Canada's immigrants and refugees and to make recommendations regarding them. Over a two-year period, the Task Force carried out its mandate by reviewing the relevant academic literature, by inviting oral presentations and written submissions and by preparing a final report, the recommendations of which are presented below.

The Task Force concluded that, while moving from one country and culture to another inevitably entails stress, it does not necessarily threaten mental health. The mental health of immigrants and refugees becomes a concern primarily when additional risk factors combine with the stress of migration.

In Canada, negative public attitudes, separation from family and community, inability to speak English or French, and failure to find suitable employment are among the most powerful predictors of emotional distress among migrants. Persons who are adolescent or elderly at the time of migration and women from traditional cultures are also more likely to experience difficulties during resettlement.

Canada can exert considerable control over these risk-inducing forces. It can provide the "ounce of prevention" needed to ensure that most newcomers will have as much chance as Canadian-born persons of maintaining their mental well-being, despite the stress of migration.

As preventive mental health measures, the Task Force recommends that:

1. The Canada Employment and Immigration Commission (CEIC) develop a multilingual series of pre-migration orientation programs in collaboration with immigrant service agencies and ethno-cultural organizations for distribution in refugee camps and at Canadian embassies abroad.

2. CEIC expedite changes in admission criteria to accommodate a broader definition of family, and changes in admission procedures to accelerate the family reunification process.

3. CEIC, Health and Welfare and Secretary of State provide core funding to immigrant service agencies to guarantee their operations on a long-term basis.

4. Health and Welfare and Secretary of State encourage and support the development of seniors' groups and programs in immigrant service agencies, general community service agencies, and ethno-cultural organizations.

5. Health and Welfare, Secretary of State, and Status of Women Canada develop and provide multilingual educational materials on women's rights and roles in Canada for discussion at immigrant service agencies, general community service agencies and ethno-cultural organizations.

6. Health and Welfare and Secretary of State work with their provincial counterparts to ensure that the curricula and environments of schools, pre-schools, and daycare facilities reflect the cultural diversity of the children attending them.

7. Secretary of State, in cooperation with provincial ministries of education, encourage and support school boards to adopt multicultural and race relations policies similar to those that have already proven successful in Canada.

8. CEIC, Ministry of Communications, and Secretary of State increase public education regarding the benefits of cultural pluralism, the contributions of immigrants to Canadian society, the difficulties faced by newcomers, and the effects of prejudice on both victim and perpetrator.

9. CEIC enable all immigrants and refugees to have equal access to official language education whether or not they are destined for the labour market. Basic training allowances must be available regardless of the immigration class of training applicants.

10. CEIC, in coordination with Secretary of State, expand and ensure the flexibility of official language training programs with respect to the level of mastery assumed, objectives of course content, duration of program, scheduling of instructional hours, and location of classes.

11. CEIC, Ministry of Labour and Secretary of State enter into negotiations with their provincial counterparts to provide criteria and guidelines for entry into professions and trades by persons trained outside of Canada.

Regarding remedial measures, the Task Force concluded that when immigrants and refugees require mental health care in Canada, they tend to seek it outside the conventional system, according to their own cultural values and beliefs. Mental health services delivered to migrants, frequently emergency and acute care services, often prove ineffective. Language and culture differences between practitioner and patient are too great in many instances to achieve successful treatment.

It is not feasible to create "parallel" mental health services for each language and cultural group in Canada, and it is not needed. With encouragement and leadership of the federal government, especially Health and Welfare, each province can provide cross-culturally accessible mental health services with existing resources and a minimum of new dollars. The Task Force recommends that:

12. Health and Welfare establish a national advisory body to coordinate and monitor social, health, and mental health services to ethnic minorities, with input from professional associations, service administration, and immigrant service agencies.

13. Health and Welfare invite requests for proposals on the development of cross-cultural training modules in education, family practice, nursing, psychiatry, psychology and social work.

14. Health and Welfare, Secretary of State and their provincial counterparts encourage institutions of higher learning to identify cross-cultural education as a priority, particularly for students of education, medicine, nursing, psychiatry, psychology and social work.

15. Health and Welfare and Secretary of State encourage all funders of social and health services to require that organizations applying for funds provide evidence of efforts to make their services to ethnic minorities accessible, and to provide evaluations of their effectiveness.

16. Health and Welfare identify immigrants and refugees as well as multicultural concerns among its priority areas for Health Promotion contributions, research and National Welfare grants, and other funded activities.

17. Health and Welfare, in collaboration with immigrant service agencies and ethnocultural organizations, develop multilingual educational materials on the psychological consequences of migration and the resources for mental health care. Health and Welfare should provide these materials to provincial ministries of health and immigrant service agencies for dissemination through front-line service providers and ethnic media.

18. Health and Welfare and its provincial counterparts encourage all social, health, and mental health service agencies to increase their hiring of ethnic minority staff by adopting equal employment opportunity policies.

19. Health and Welfare and Secretary of State encourage the admissions committees of social, health and mental health service training programs to recognize as assets fluency in a non-official language and the intention to work with clients who speak that language.

20. Health and Welfare encourage provincial mental health services to employ mental health practitioners at major immigrant service agencies.

21. Health and Welfare, in collaboration with provincial ministries of health and immigrant service agencies, develop a curriculum for training interpreters used by mental health services. Immigrant service agencies and provincial ministries of health should be provided with this curriculum for use in classes supported by Health and Welfare.

22. Health and Welfare support research and health promotion initiatives to define the psychological consequences of torture, and to develop effective treatment programs for torture victims and their families.

23. Health and Welfare encourage provincial mental health services to give special consideration to the funding of ethno-specific rehabilitation and reintegration facilities.

The Task Force recognizes that the cost-effectiveness and ultimate success of any given preventive or remedial measure depends heavily on the knowledge and experience on which it is based. The need for accurate, empirical research findings, for controlled program evaluations, and for the coordinated monitoring of information and activity are noted throughout the report. It is therefore recommended that:

24. CEIC, Health and Welfare and Secretary of State establish at least three centres of excellence across Canada for research on issues affecting migrant mental health.

25. CEIC, Health and Welfare and Secretary of State establish at least three centres of excellence across Canada for cross-cultural training.

26. CEIC, Health and Welfare and Secretary of State establish a single, computerized information centre to collect, coordinate and disseminate the results of research and evaluations as well as descriptions of service and training programs directed to migrants and ethnic minorities in Canada.

27. Health and Welfare and Secretary of State create a national body to advise on and monitor the implementation of the Task Force recommendations.

In implementing these measures to address the mental health needs of immigrants and refugees, Canada will not only serve its own best interests; it will also affirm its status as a caring nation.

Part I:

Introduction

In Canada, as elsewhere, new settlers encounter obstacles in pursuing the goals which they and other Canadians value. Too often, newcomers, stigmatized because of their immigrant status, feel barred from what they perceive to be the mainstream of Canadian society. Alienation and frustration may result in poor mental and physical health. In recognition of these problems, and in response to the concerns of a number of national organizations, the Multiculturalism Sector of the Department of the Secretary of State, and Health and Welfare Canada, formed a Task Force to investigate mental health issues affecting immigrants and refugees in Canada, this "country of immigrants".

Composition of the Task Force

The Task Force, formed on April 1, 1986, included psychiatrists, psychologists, nurses and social workers. Some were academics, others "front line" providers of services to immigrants. Members, who included native-born Canadians as well as others who had emigrated from Argentina, El Salvador, Hong Kong, Jamaica, the Philippines, South Africa and Vietnam, came from almost all parts of the country — from Atlantic Canada to British Columbia. The Task Force was complemented by a full-time Research Coordinator. Two organizations were responsible for administration: the Canadian Mental Health Association (CMHA) and the Department of Psychiatry, University of British Columbia (UBC). Staff from Secretary of State — Multiculturalism, Health and Welfare, and Employment and Immigration Canada lent expertise and help.

The Work of the Task Force

The two-year mandate of the Task Force was straightforward:

1. to prepare a summary of relevant background and research literature dealing with mental health issues affecting immigrants and refugees;
2. to conduct national hearings to determine the environment for the mental health needs of newcomers, to understand patterns of settlement and adaptation, and to define the availability of and accessibility to care-giving organizations as well as the characteristics of caregivers; and
3. to prepare a final report and recommendations.

The Approach to the Mandate

Completing the tasks proved far more complex than defining them. Working evenings and weekends, the group began its task by searching the research literature and reviewing unpublished reports. Members of the Task Force prepared analyses of topics within their areas of expertise. These materials were integrated at the offices of the Chairman at UBC to become the first report to the sponsoring ministries. This background paper, ***Review of the Literature on Migrant Mental Health***, summarizes the Canadian and, to a certain extent, world literature on mental health and resettlement.

In preparation for the national hearings, the Task Force contacted more than 700 service agencies, ethnic organizations, immigrant and refugee self-help groups, universities and training institutions. The letters advised that a Task Force had been formed, described its nature, and invited oral and/or written submissions addressing mental health concerns of immigrants and refugees. Although the response to the invitations was gratifying, we could invite only a sample of agencies and individuals to make oral submissions.

On April 10 and 11, 1987, the Task Force received presentations by 19 Western Canadian organizations in Vancouver. The following month, on May 6 and 7, Task Force members reassembled in Toronto, where we heard from 20 organizations in central Canada; in Montreal, on May 8 and 9, we received 15 submissions from Quebec and the Atlantic provinces.

Community Response

The public hearings were remarkable. Briefs were submitted on behalf of groups ranging from small, isolated ethnic associations to umbrella organizations representing large segments of our most populous cities. Submissions came from established social service and health agencies struggling to meet the needs of clientele they found difficult to understand, from institutions experimenting with new training programs for providers of care, and from self-help groups that lacked resources but not ideas. Since people who are busy delivering services typically have no time to write about their work, the opportunity to hear them describe innovations evolving throughout Canada proved particularly valuable. The insights derived from these experiences provided an important lesson. While it will not be necessary to create a new system of services to meet the mental health requirements of immigrants and refugees, existing resources can and must become more accessible and responsive.

Other meetings took place outside the formal hearings. During one evening in Toronto, we convened an open public forum attended by about 100 persons. Some came because of personal interest, while others represented groups who had not been able to make a formal presentation at the hearings.

The Chairman also met with representatives of provincial ministries responsible for social, health and resettlement services in Alberta, Manitoba, Quebec and New Brunswick to hear of government-sponsored initiatives to meet the mental health needs of newcomers.

A flood of written submissions was received, describing the problems migrants encounter in adapting to life in Canada, as well as creative attempts by community and government agencies to understand how best to meet the needs of newcomers and to develop programs to put this new understanding into practice.

Concepts and Definitions

Complex studies usually have a unique vocabulary which requires definition: one peppered with terms like **"mental health," "immigrants," "refugees"** and **"mental health services"** is no exception.

Ironically, the term "**mental health**" has come to mean both mental disorder and positive mental health.

Mental disorders cover phenomena ranging from serious illness for which people are hospitalized to the unrealistic fears or inconsolable episodes of sadness which interfere with people's ability to work and to love. At times, the term has also included the personal effects resulting from difficulties people experience when faced with life changes, such as puberty or bereavement, or when they look to the mental health professions for help with marital problems. Official nomenclatures such as the International Classification of Diseases (ICD), Mental Health Section, or the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) not only describe these problems but define them as the legitimate province of the mental health field.

A large percentage of the general population — research places it as high as 15 to 20 per cent — suffers, in varying degrees, from emotional disorders of the types described in the ICD or the DSM. Their commonness should not blunt our sensibilities to the enormous toll these conditions take in individual suffering and the cost of providing care. Some authorities suggest that 30 per cent of all medical care contacts are for mental health-related problems. Thus, emotional distress creates enormous costs to societies.

Like everyone, migrants may suffer **distress** of different types, of different intensity and for different periods of time. A large body of theory suggests that, because resettling in a foreign country is undeniably a source of stress, immigrants and refugees will have more mental disorders than the host country populations. Many of the studies in our survey of the world literature on migration support this belief. However, an approximately equal number suggest the reverse; immigrants either have the same rates of disorder as the host country population, or, in some cases, lower rates. While this might suggest that scientists who conduct this type of research are hopelessly confused, reviews of these carefully designed and well-executed studies lead to a more interesting conclusion.

Migration is a condition of risk for developing mental disorder. But risk is not destiny. Some migrants, under certain conditions, become mentally ill. However, differences in personal characteristics or in the social situations in which migrants find themselves are more powerful predictors of mental health outcome than migration per se. Rather than asking whether migrants have more mental disorder than others, we need to understand under what conditions migrant populations experience higher or lower rates of emotional disorder than native-born groups.

While the Task Force was concerned about mental disorder, we felt that our scope must go beyond the boundaries of illness to encompass health in a positive sense. Trying to encompass positive health is a bit like chasing mercury; it is easy to sense the phenomenon but hard to capture the substance. Scientists have long debated the meaning of health. The World Health Organization (WHO) produced a definition making the important point that health refers to more than the absence of disease. The rhetorical appeal of the rest of the WHO definition, "a complete state of physical, psychological and social well-being," however, is difficult to translate into concrete terms.

While scientists and professionals continue their struggle to define **health** in its positive sense, the Task Force adopted a concept which probably accords with that of the proverbial man and woman on the street. To the extent that people are happy, have a sense that they are fairly well in control of their lives and feel that they are valued, productive members of society, they are mentally healthy. The Task Force concluded that in addition to trying to understand the factors which make migration a risk-inducing situation for mental illness, we also had to identify the forces which promote the optimization of human potential.

"**Immigrant**" and "**refugee**" are two more terms requiring definition. We admit people to Canada under the *Immigration Act* predicated on economic, social and humanitarian concerns. People may enter in one of three categories: family class, Convention refugees and independent immigrants.

Under the terms of **family class**, any Canadian or permanent resident who is at least 18 years of age can sponsor close relatives by signing an undertaking to provide for lodging, care and maintenance of his or her family members for a period of up to 10 years.

The **independent class of immigrants** includes assisted relatives, retirees, entrepreneurs, investors, and others applying on their own initiative. Applicants in the independent class are assigned points based on education, vocational training, experience, personal stability, and having relatives in Canada. In order to be admitted in this category, an applicant must receive at least 70 points out of a possible 100. A bonus of 10 points is awarded to persons with relatives in Canada who can and will act as guarantors.

Canada's definition of refugee is based on the United Nations Convention and Protocol Relating to the Status of Refugees:

> *A "Convention refugee" is "any person who by reason of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group or political opinion (a) is outside the country of his nationality and is unable or, by reason of such fear, is unwilling to avail himself of the protection of that country, or (b) not having a country of nationality, is outside the country of his former habitual residence and is unable or, by reason of such fear, is unwilling to return to that country."*

Many persecuted and displaced persons who do not qualify as refugees under the U.N. definition can be admitted as specially designated classes for humanitarian reasons. In recent years, the federal government has admitted, in the designated class category, persons from Southeast Asia, Poland and some Latin American countries.

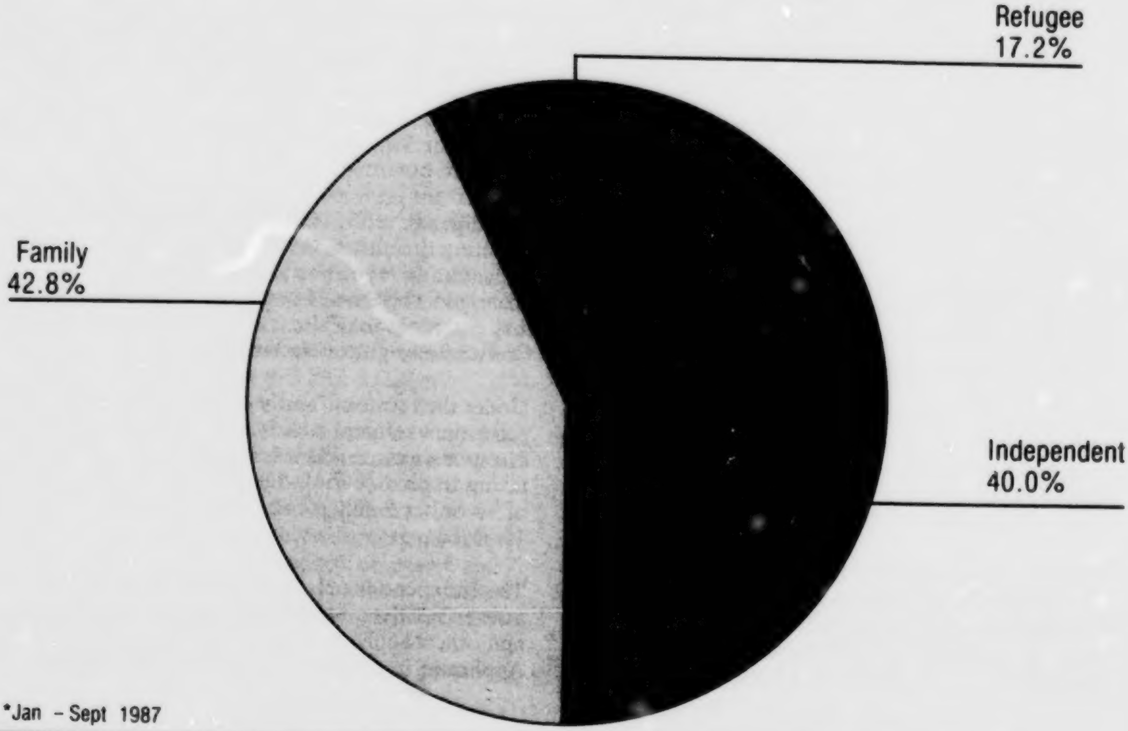
At times, we use the terms **"migrant"** or **"immigrant"** in this report to cover persons in all categories: family class, refugees, designated class and independent immigrants. The term does not, however, include foreign students or temporary workers, people who were not included in the Task Force's mandate.

The numbers of persons entering Canada has varied over the past decade from a low of 84,331 in 1985 to approximately 152,000 in 1987. As Figure 0.1 shows, just over 17 per cent of these immigrants have been admitted as refugees, 40 per cent have arrived in the independent class, and almost 43 per cent in the family class.

Figure 0.1

Distribution of Immigrants by Immigration Class

Canada 1978-1987*



*Jan – Sept 1987

Finding one's way in a new society is a bewildering experience. Whether a person comes to Canada in the hope of carrying on a business, to reunite with a relative or to escape political persecution, adapting to the host country and its ways creates common problems. Many new settlers, whether immigrant or refugee, speak neither of Canada's official languages. Many come from societies dominated by values that differ from those most Canadians share about such things as health care. Language, the compatability of cultures, and attitudes towards health care are major concerns for a multicultural society. They also affect the mental health of newcomers.

While immigrants and refugees share many common problems, they also differ in ways which have important mental health implications. People usually choose to become immigrants, whereas they are forced to become refugees. This increases the risk for emotional disorder. Many refugees have experienced the loss of home and possessions, the deaths of friends and family, internment in refugee camps, and perhaps torture, which breaks minds as well as bodies. To add to the trauma of their past, when refugees arrive in a country of asylum, they are usually poor and are cut off from families and other sources of social support. Most refugees are admitted to Canada from abroad. However, recent years have witnessed an increase in refugee claimants, persons who appear on Canadian soil claiming refugee status under the Geneva convention. While there have been well-publicized abuses of this system, many claimants ultimately qualify as bona fide refugees and are permitted to stay. The desperation which prompted their decisions to appear in Canada and then apply to stay, coupled with the long delays which invariably precede a hearing of their cases, generate stress for claimants awaiting judgements. Ironically, until their refugee status is established, this high-risk group is not eligible for health care benefits.

Understanding mental health needs and the factors affecting these needs constituted an important part of the Task Force's work. It was equally important to study how Canada is responding — and with what kind of success.

We frequently heard about the "**mental health care system**." We even used the term ourselves, recognizing that in doing so, we were perpetuating a convenient fiction. There is no monolithic "system" to cure and rehabilitate the mentally ill or to promote the well-being of Canadians. Instead, there are hospitals, clinics and private practitioners offering various services, sometimes working together, sometimes not. Moreover, not all the counselling and curing of the emotionally disturbed, and even less of the health promotion, happens in these places. A great deal of it transpires informally, in physicians' offices, in second-language classrooms, in immigrant and refugee service agencies, in neighbourhood settlement houses and among the participants in ethnic self-help organizations.

Schools and pre-school programs also play a role in the "mental health care system." Children learn more than basic skills at school and in pre-school programs. The attitudes immigrant children encounter in these settings help forge developing identities. This, in turn, affects their parents. Many immigrant families make their adjustment to a new country through their children's experiences and aspirations.

The term "**mainstream**," referring to organizations seen to be central to the Canadian way of life and endorsed by most Canadians, was frequently used as a contrast to "ethnic services," connoting institutions which play a more marginal role in our country. This is ironic. In our multicultural society, discourse which implies that some of our institutions are more central than others has no place. All social and cultural institutions, whether large or small, whether supported by groups who have been in Canada for generations or for just a short while, are important and central to our way of life. "Mainstream," which suggests an image of a central channel towards which tributaries will flow to mingle and be absorbed is a misleading metaphor. The central image of a multicultural society is a mosaic — a pattern built of identifiable units. For these reasons, we have attempted to avoid the term "mainstream," substituting instead phrases such as "larger society" or "host society" or "general community" institutions.

Was This Effort Necessary?

Most Canadians, if they are not first-generation immigrants themselves, have a parent, grandparent, aunt, uncle, cousin or friend who came to Canada from another country. Some of these Canadians said: "Yes, times were hard, but I (or my relative) overcame all that trouble without any help from the government. We made it on our own in this country. Why do we need special inquiries and special programs now?" It's a legitimate question, and one based on incontrovertible evidence.

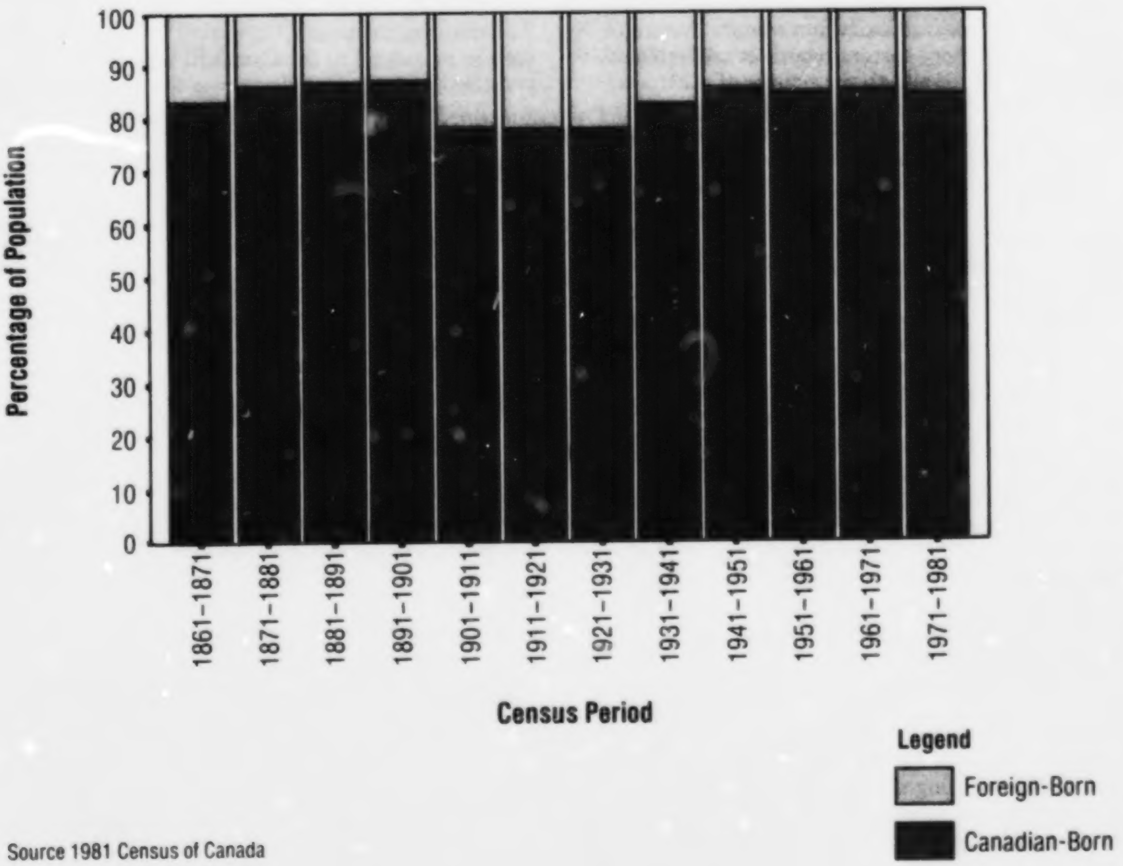
In 1988, one in six Canadians is foreign-born. It is remarkable that, as Figure 0.2 illustrates, the ratio of foreign-born to Canadian-born has, ever since Confederation, never been less than one in six, and sometimes as high as one in five. Obviously, during the 120 years of this nation's history, most new settlers have, through hard work and perseverance, "made it" and contributed to the Canadian way of life.

The need for a new and special examination of mental health factors affecting immigrants and refugees arises from two sources: the changing face of immigration in Canada, and the expanding range of our knowledge about factors affecting the way in which new settlers adapt.

Figure 0.2

Percentage of Canadian-Born and Foreign-Born in Total Population by Census Period

Canada 1861-1981



Source 1981 Census of Canada

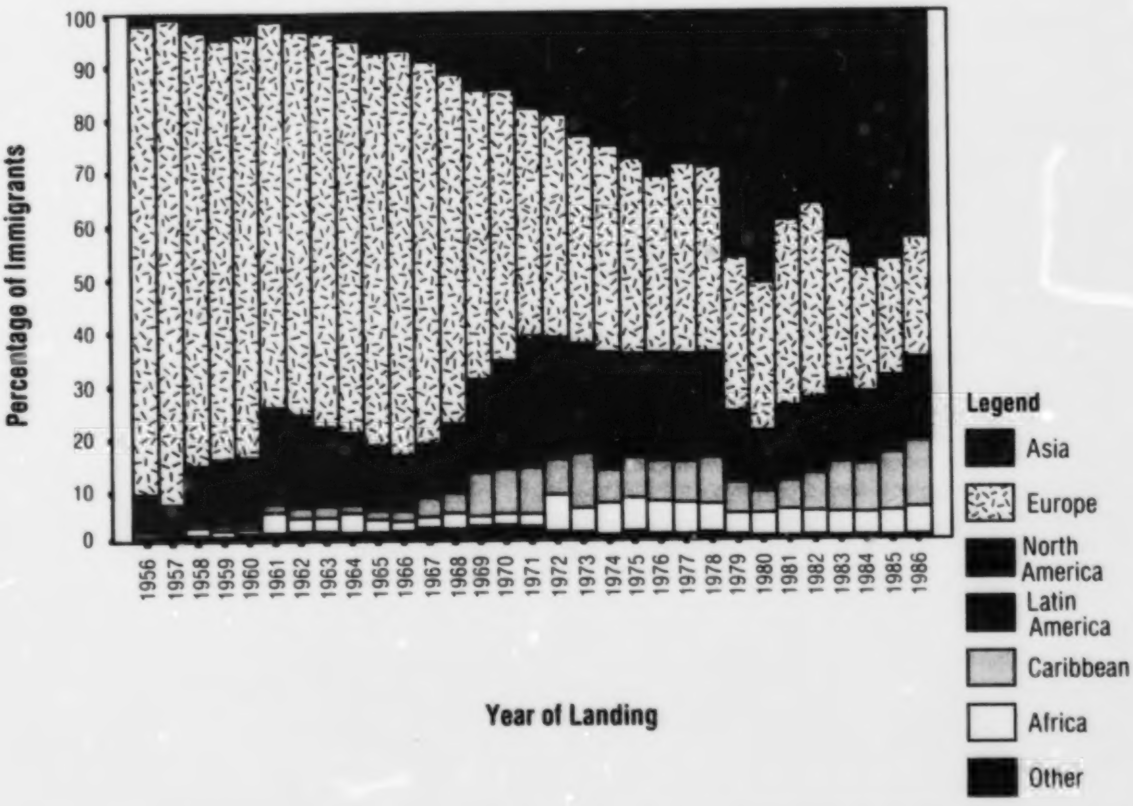
Recent immigrants to Canada do not come from the same places as their predecessors. As Figure 0.3 demonstrates, early migration to Canada was dominated by movements from Europe. During the last two to three decades, the proportion of immigrants from that part of the world has shrunk, while the numbers from Asia and, more recently, Latin America, have expanded.

Early generations of migrants, coming predominantly from northern Europe, had to adapt to new climates and new customs, without much preparation and without much help. Later settlers, from places like Poland, Ukraine, Greece, Italy and Turkey suffered the additional stress of not speaking one of Canada's official languages. The most recent migrants, particularly those from areas such as Southeast Asia, India and Eritrea, often speak languages whose roots are entirely different from those which evolved into the tongues spoken by European-origin migrants. They also hold ideas about the place of family in one's life, about religion, and about how society should be organized that are vastly different from those of most Canadians.

Figure 0.3

Regions of Origin by Year of Landing

Canada 1956-1986



If we accept the idea that unfamiliar surroundings compound the stress involved in starting life over — and our data overwhelmingly support this concept — the character of our current immigration patterns dictates a new attention to resettlement and to the factors which facilitate it. Fortunately, we know considerably more now than we used to about what makes resettlement difficult and how the difficulties can be eased. It is incumbent upon us to apply this new knowledge to optimize the newcomers' sense of well-being and ability to contribute to society. Anything less would be a disservice, both to Canadian society and to the individuals who have been invited to join it.

Organization of the Task Force Report

In recognition of the fact that it is best to prevent problems from ever developing, the report begins with a section devoted to policies and practices which help prevent mental distress and which promote well-being among immigrants. Separate chapters address Canadian attitudes towards newcomers and the social support available to them, language education and employment opportunities.

Even with the most effective preventive programs in place, remedial services will always be required for those who, as a result of a combination of personal predisposition and adverse circumstance, develop mental disorders. Our section on remedial measures examines the relationship between immigrants and Canada's mental health care system. One chapter examines formal mental health services and another addresses actual and potential sources of care which exist outside of the formal mental health service network. The issues of training for mental health practitioners and licensing of immigrant mental health professionals are also included in Part III: Remedial Measures.

Particular categories of immigrants are at higher risk for emotional problems than are others. In Part IV, the special needs of these immigrants — children and youth, women, seniors, and victims of catastrophic stress — are addressed with regard to both preventive and remedial measures.

Each chapter of the report defines the specific issue addressed and analyses the policies and practices affecting it. This information summarizes the knowledge and understanding gained from the scientific literature and from community submissions. Each chapter includes recommendations.

The Mandate of the Task Force

In many ways, Canada's treatment of immigrants is a model for the rest of the industrialized world. Admiration for our humanitarian response to the world refugee crisis received indisputable expression in the form of the 1986 United Nations Nansen Award, the first time this recognition had been accorded to an entire nation. The Canadian Charter of Rights and Freedoms and our new ***Canadian Multiculturalism Act*** speak of a national policy of fairness and equity, both for citizens and landed immigrants and refugees.

Canada's birthrate has fallen in recent years, despite a national goal of maintaining, if not increasing, the population. Our commitment to providing asylum and facilitating immigration is, therefore, based not only on the humanitarianism of which Canada is justifiably proud, but also on enlightened self-interest. Canada benefits from the labour, the capital and the creative potential of new settlers. Because there is no reason to believe that the century-long pattern of admitting settlers will change, this report is prepared in the hope that its findings will help us to provide a more effective welcome to the strangers to whom we shall continue to open our doors.

Part II:

Prevention

Chapter 1:	Attitudes of Canadian Society	11
Chapter 2:	Settlement and Social Support	15
Chapter 3:	Official Language Education	23
Chapter 4:	Employment	29

Canada's health care policy, described in ***Achieving Health for All: A Framework for Health Promotion*** (1986), defines prevention as an overarching goal. While Canada can do little to reduce stresses occurring prior to migration, research and experience repeatedly demonstrate that what happens to people after they enter a country of resettlement has profound mental health consequences. **Since we can alter post-migration conditions for newcomers, it is important to delineate and understand factors which affect mental health during resettlement.** Drawing on the testimonies of migrant groups and resettlement agencies, as well as research literature, this section deals with four significant areas: attitudes of Canadian society towards newcomers; settlement and social support; official language education; and employment opportunities.

While Canada's ***Immigration Act*** recognizes an important role for migrants in developing this country, and our ***Canadian Multiculturalism Act*** affirms the value of cultural diversity, Canadians do not share a uniformly welcoming attitude towards newcomers, particularly those with visible minority origins. The report of the All-Party Parliamentary Special Committee on Participation of Visible Minorities in Canadian Society, published under the title ***Equality Now!*** (1984), documents the alarming finding that 15 per cent of Canadians exhibit blatantly racist attitudes and an additional 20 to 25 per cent have racist tendencies.

Racism violates our assumptions about the kind of people we are. Efforts to enhance mutual respect and to celebrate differences are important for the mental health of native-born Canadians as well as newcomers.

In recent years, we have become increasingly aware that individual well-being depends on having meaningful ties to other individuals. People require a supportive social group in order to reaffirm their self-esteem. Testimony presented to the Task Force reveals that group memberships are threatened during resettlement but community development programs can help restore the sense of belonging which promotes mental health.

Inability to speak the language of the host country is a severe handicap because it leads to alienation and emotional disorder. Language acquisition, therefore, forms an important component of this report.

Studies of unemployment in the general population suggest links with increased rates of suicide, hospitalization for psychiatric disorder and threats to general well-being. Often the last to be hired and the first to be fired, migrants experience higher rates of unemployment than the indigenous population. They often find themselves in situations where they are cut off from buffers to stress such as social support, which offset the effects of unemployment on mental health.

Persons who are alienated from the majority culture, cannot speak its language or find work and who, at the same time, are deprived of their customary sources of social support do not belong anywhere. Their risk of developing emotional disorder is great. Without the help of preventive programs, they become marginal rather than full participants in Canadian society. Through this process, they may become one of the country's mental illness statistics.

Most migrants have proven resilient even in the face of risk. Most have overcome hardship to make great contributions to Canada. Their success provides important guidelines for ways in which the relatively small group who become casualties of resettlement might be helped to adapt more quickly and more easily.

There is evidence that the migrant with the best chance of maintaining a sense of well-being is probably the one who has the most options — the person who is able to maintain links with his own ethnic community but who is also welcome in the larger society and able to participate fully in it.

There will always be a need for remedial health services. However, the search for ways to prevent illness and suffering and to promote well-being, now barely begun, must be encouraged.

Chapter 1:

Attitudes of Canadian Society

The Issue

The reception afforded immigrants by the host society affects their mental well-being. Government policies which foster integration and pluralism, and public support for cultural and racial diversity, allow newcomers to participate in the larger society without having to give up their historical and cultural identities. The ideology of multiculturalism accords well with mental health. People with options — to wholeheartedly embrace a new culture, to preserve their own or to combine the two — are likely to maintain their mental health. Curtailing options through forced assimilation or isolation jeopardizes health and well-being. While Canada's policy of multiculturalism should help create optimal conditions for immigrant adaptation, the way in which these policies are implemented and the climate of popular opinion compromise this potential. The gap between "ideal" policies and "real" behaviour must be narrowed.

Federal Policies

In Canada, we are guided by a Multiculturalism Policy (Government of Canada, 1971) and the new multiculturalism legislation. These documents, supported by a number of parallel provincial initiatives, define us as a society respectful and welcoming of diversity. Canadians are encouraged to maintain their heritage languages, customs and beliefs, and to project the multicultural reality of Canada in their activities at home and abroad.

Canada's multiculturalism policy should be conducive to immigrant mental health. However, the manifest attitudes and behaviour of many Canadians towards newcomers often deviate from the ideals to which the principles subscribe. All Canadians must become aware of and fully appreciate the principles of multiculturalism. To quote one submission, "(we) must mainstream Multiculturalism" (Surrey School District 36, B.C.).

Attitudes in the General Population

Canada, in recent years at least, has earned its reputation as a humanitarian nation. A number of recent studies, however, reveal that a substantial and perhaps growing proportion of Canada's population displays morbid dislike of foreigners and displays racist attitudes.

A report released by the Canada Employment and Immigration Commission (CEIC) in 1985 documented xenophobic attitudes harboured by many Canadians. Many people felt that Canada's culture — perceived as deriving from northern Europe — was in danger of being overwhelmed by non-European immigrants unwilling to assimilate. Immigrants were also seen to pose an economic threat. They were indicted for taking jobs and thus driving up unemployment among Canadian-born persons and, conversely, for failing to find work and thereby becoming a drain on the country's welfare system. As several submissions to the Task Force noted, the perception that immigrants jeopardize our economy is particularly acute in depressed regions of Canada where "chronic unemployment encourages a resentment towards immigrants who are viewed as competing for jobs and draining the economy." (Submission: Association for New Canadians)

Many Canadians place ethno-cultural groups on a scale of acceptability. Anglo-Celtic, French and northern Europeans occupy the top end of the scale, southern and eastern Europeans the middle, and Asian and Caribbean groups the bottom (Berry, Kalin and Taylor, 1977). Members of groups at the bottom of the scale, Canada's visible minorities, experience rejection every day — on the job, in housing, in education, in the media and on the street. While research has yet to establish causal links between discrimination and mental disorder, it is hard to imagine that the relentless experience of rejection does not jeopardize one's mental health.

> ***The basis for much of the mental health problem in Canada is a moderate, systemic racism throughout our society. To be sure, it is not as blatant or as extreme as in the past. Even so, the racism that lingers is still powerful enough to place visible minority people under the pressure of always being on watch for the hard edge of prejudice and discrimination. It is the individual representation of this racist plague that underlies, we think, many of the psycho-social problems immigrants and refugees manifest.***
> ***(Submission: Herberg and Herberg)***

Options for Attitudinal Change

Community submissions and academic studies suggest three broad strategies for modifying Canadian attitudes towards immigrants to reflect the goals of Canadian policies.

Education through school curricula provides a highly effective means of improving inter-ethnic relations, but its ultimate success will be seen only in the long term.

A number of school boards, schools and individual teachers across the country have been, and continue to be, intent on promoting cross-cultural understanding in the classroom. Their experience suggests, and research confirms, that multicultural curricula are most effective when they are:

- first introduced in early childhood;
- oriented towards inter-cultural activities; and
- facilitated by teachers who themselves have been educated in cross-cultural awareness.

Professionally guided multicultural activities, especially among younger pupils, serve a dual purpose regarding immigrant mental health. They enable majority group children to accept and value others, and to grow up with fewer racial biases. They also foster the self-esteem of minority group children (Chapter Nine).

Public education is a potentially productive way of improving the welcome extended to immigrants. There have been commendable efforts to describe the mutual benefits of immigrant-host country relationships and to further an understanding of the cultural background of migrants. For example, newspaper headlines such as "Immigrants Create Jobs" emphasize the economic benefit of our immigrant policies, while film footage on the plight of asylum seekers reinforces the humanitarianism underlying acceptance of refugees. But are these messages reaching anyone other than the already converted? One journalist suggested that "until [the Minister of State for Immigration] and his department abandon their wilful disregard of the scope of racism among Canadians, it is unlikely that their advertising program will have a discernible impact on public attitudes towards immigration" (Malarek, 1987, p.79). Stated more positively, research findings need to be combined with good marketing techniques to produce effective public education.

Policy and legislation at provincial, municipal and community levels can block harmful actions resulting from negative attitudes.

While public behaviour can be legislated, feelings can only be influenced. Several submissions to the Task Force noted that a school race relations program, a municipality's fair housing policy, or a decision by the Human Rights Commission all help improve the treatment experienced by immigrants. Ideally, policies guiding behaviour should be complemented by educational programs designed to ensure that the spirit as well as the letter of the law is understood and accepted. The race relations policies adopted by the Province of Ontario and School District 36 in Surrey, B.C. are examples of this constructive legislation. For the most part, however, efforts at modifying behaviour have not incorporated attitudinal change.

The federal government has a limited but essential role to play in modifying behaviour towards immigrants through provincial and municipal policies. It can facilitate the research on which sound policy decisions, as well as effective public education efforts, should be based. As a working paper of the Ford Foundation (1983) concludes, "Until basic studies are conducted on these matters and until the results of those studies are widely disseminated, it will be difficult to frame and gain acceptance for appropriate policies."

The federal government can become a model for desired behaviour through policy decisions made within its own jurisdiction — by, for example, providing equal employment opportunity. Policies which prove successful at one level of government provide solid examples for consideration at other levels.

Federal input to national bodies such as the Canadian Radio-Television and Telecommunications Commission, and to joint federal-provincial bodies such as the Conference on Educational Resources, can present immigrant perspectives on any issue. Where federal funding or matching funds agreements are at stake, Ottawa has a clear mandate to address the concerns of all Canadians — whether native-born or foreign-born.

Conclusions

Among the many factors determining whether migration will be a negative or positive experience, the orientation the host society displays towards newcomers is among the most important. Attitudes of government and the general population establish the emotional context in which immigrants see themselves and act. Perceived hostility may only breed further hostility, both in the immigrant and host communities, with a consequent rise in mental health problems for all. If the governing factors can be identified, assessed and managed, then the goal of a culturally pluralistic society, a celebration of diversity, can be attained.

Those of us already here learn from and respond to newcomers. In the process, we and they change. Migration creates adaptive stress for members of the host society as well as for newcomers. Because adapting to newcomers may be stressful, the host society may react by becoming hostile. The unwelcoming climate which results increases the risk of frustration and mental illness among migrants, which may in turn make the backlash in the larger society more intense. For these reasons, any public policy or program concerned with mental health needs of immigrants and refugees must also concern itself with the needs of the general population. This is an interactive view of how people negotiate their way in a plural society. It draws attention not just to the mental health needs of immigrants adapting to a new society but also to the needs of Canadian-born persons adapting to a changing society.

The needs of the host population for understanding and acceptance of the changes immigration entails may be met in part through public education and school curricula. In both cases, educational objectives should include:

a) the benefits of the pluralistic nature of Canadian society, and the federal and provincial policies of multiculturalism designed to maintain this pluralism;

b) the historic role of immigration in building Canadian society and the contributions of people from different cultures;

c) the humanitarian values and respect for human rights which underlie Canada's policies;

d) the problems typically experienced by immigrants and refugees both before and after migration;

e) the awareness that all people have a potential to express prejudice and to act in discriminatory ways even if they do not necessarily intend to do so; and

f) the understanding that prejudice damages both the victim and the perpetrator.

Such information and understanding would aid Canadians in adapting to immigrants, and would, therefore, exert a positive impact on the reception experienced by immigrants. The Task Force recommends **that CEIC, Ministry of Communications, and Secretary of State increase public education regarding the benefits of cultural pluralism, the contributions of immigrants to Canadian society, the difficulties faced by newcomers, and the effects of prejudice on both victim and perpetrator.** An interministerial committee comprising senior staff from the respective ministries should, in consultation with ethno-cultural community groups, make recommendations for increased funding, facilitate the introduction of new public education programs, and monitor progress.

Immigration will continue to be a part of Canadian policy, and immigrants a part of Canadian life. If today's school-aged population understands and accepts its immigrant peers, it will help ensure a positive welcome for newcomers arriving years from now. The curricula of pre-school, elementary and secondary schools should pay more attention to the same themes identified as objectives for public education. Provincial ministries of education should provide direction in this regard, with the encouragement and support of CEIC, Health and Welfare, and Secretary of State.

Positive changes in attitudes towards immigrants will come slowly among adults and will come to fruition among children as they become adult members of society. On the other hand, positive changes in public behaviour can be directly affected, particularly among children. It is recommended, therefore, **that Secretary of State, in cooperation with provincial ministries of education, encourage and support boards of education to adopt multicultural and race relations policies similar to those that have already proven successful in Canada.** This recommendation should be placed on the agenda of the Federal/Provincial Conference on Educational Human Resources for implementation.

The success and cost-effectiveness of race relations policies and educational programs depend on accurate assessments of the problems they are designed to address. While the Task Force agrees in general on the need for education and policies to facilitate a positive reception of immigrants, it also acknowledges a need for more information about how attitudes and behaviour can be most effectively modified. The abolition of racism is in itself a worthy goal for a truly pluralistic society. However, the Task Force's mandate concerns the mental health of newcomers. While it seems inconceivable that prejudice is not damaging to mental health, the empirical evidence linking the two is inadequate as is an understanding of how discrimination may result in mental ill-health.

Funds for a substantial research program should be allocated by CEIC, Health and Welfare, and Secretary of State to discover the level, nature and sources of prejudice in Canada. Research should also address the link between prejudice and discrimination and the mental health of immigrants and refugees in Canada.

With accurate information, programs and policies can be developed to enable host Canadians to adapt to newcomers and to welcome them. The Task Force affirms the belief that such efforts will result in mutual benefit. As Dr. Hung-Tat Lo stated in his submission, "An environment where discrimination and xenophobia give place to mutual respect and cultural diversity can only be a healthier environment for all."

Chapter 2:

Settlement and Social Support

The Issue

To begin life again in a new country, migrants need practical assistance, psychological support and personal stamina. Immigrants and refugees who do not speak the language of the host country, or who, because of race or ethnicity, become objects of discrimination, often need special help during resettlement.

Migrants to Canada have several potential sources of assistance and support: relatives and friends, ethno-cultural community groups, and social and health service agencies. The amount and quality of support actually received from these potential sources has a direct bearing on mental health.

Role of Family and Friends

Both the research literature and submissions to the Task Force emphasize the psychosocial support provided by family as an important resource for promoting well-being and preventing emotional disorder. As the Family Service Association of Metropolitan Toronto put it, "The support of family members is invaluable in the resettlement process."

Definitions of "family" vary. In many cultures, close family includes people who, in Canada, are considered "relatives" — cousins, aunts and uncles, nieces and nephews. In industrial societies like Canada, the intensity of the relationships between siblings and between parents and children diminishes over time. But in many societies, it retains its power even after siblings or children marry.

Regardless of age, members of the nuclear family — parents and children — and extended family such as grandparents, uncles, aunts and cousins play important roles in each other's lives. Separation can create emotional, financial, or political vacuums. The Association for New Canadians cites three cases of wife abuse which "might not have become so bad...if members of the extended family were in Canada with the immigrants." In these cases, it seemed likely that the extended family would have provided emotional support and reinforced cultural norms. This would have created more constructive outlets for the dissipation of intrafamilial tensions than the physical violence which brought these cases to official attention. Migrants fortunate enough to have extended family with them benefit from a psychosocial resource which can make their adaptation to a new life easier, particularly during the early years of resettlement.

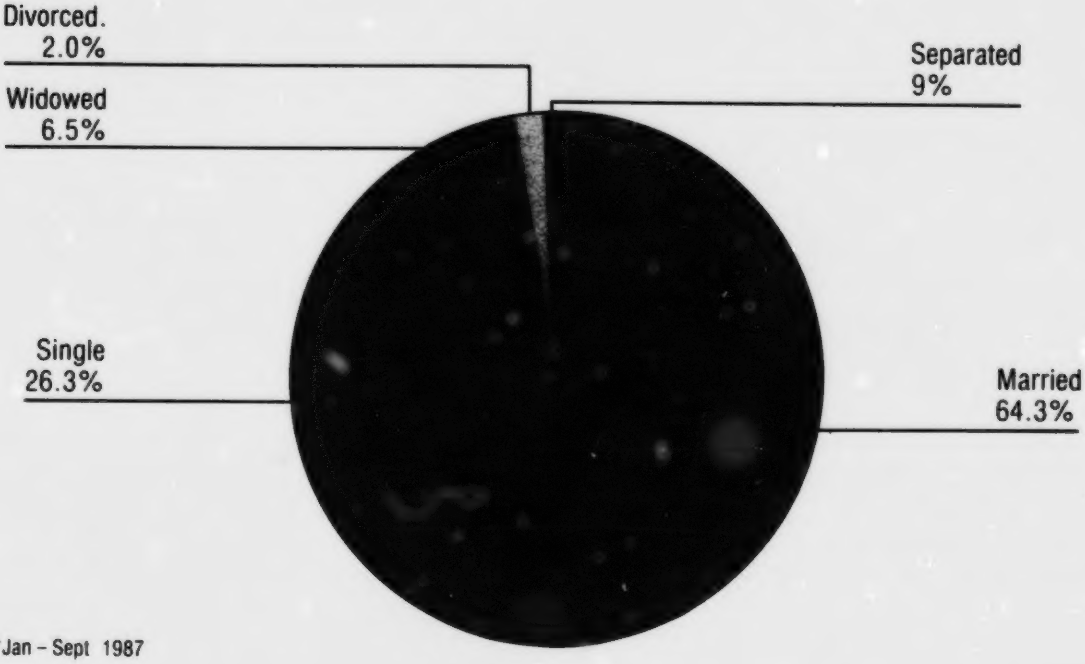
Persons who have been separated from family by events beyond their control — like many refugees, for example — are in a situation of double jeopardy; they are bereft of potentially important sources of support during a difficult time and worry about the welfare of family left behind. This can create stress leading to anxiety and depression.

As Figure 2.1 indicates, over 35 per cent of adults immigrating to Canada between 1978 and 1987 were either single, widowed, divorced or separated.

Figure 2.1

Distribution of Immigrants 20 Years and Older by Marital Status

Canada 1978-1987*



*Jan – Sept 1987

Reunification after separation may not lead to consistently positive results. Spouses separated for long periods may find readjustment difficult.

Nevertheless, even reunited couples can cope better with the stress of adaptation than single or separated immigrants (Submission: Ontario Welcome House). The University of British Columbia Refugee Resettlement study of 1300 Southeast Asian newcomers documented higher rates of depression and anxiety among single, separated, divorced or widowed persons than among those who were living with their spouses: those people who reunited with spouses or went on to marry during the two years of the study experienced improved mental health.

Friendships are also important, so much so that they may serve as substitutes for missing family relationships (Kurien, 1980). Such friendships most naturally occur between persons of the same ethnocultural group, but a number of submissions to the Task Force suggest that relationships between immigrants and host Canadians of various cultural backgrounds can also "greatly reduce the loneliness and social alienation often experienced by immigrants" (Submission: Kingston and District Immigrant Services).

> *Ongoing support for the Host Family and Friendship Family programs that encourage people to befriend newcomers is a very cost-efficient way to ensure support mechanisms for those who may have or develop mental health problems during and after settlement. Proper training of the hosts is important so that they understand the potential problems and do not react to aberrant behaviour in inappropriate ways.*
> *(Submission: Centre for Research and Education in Human Services and Kitchener-Waterloo Refugee Co-ordinating Committee)*

Host and sponsorship programs have made it easier for refugees and immigrants to be admitted to Canada and to receive practical assistance during the early years of resettlement. While the importance of these programs is well recognized, the powerful influence that host and sponsor actions may have on immigrant mental health has not received sufficient attention. Studies have shown that pressure to adopt a sponsor's religion creates stress for grateful and dependent newcomers (Kitchener-Waterloo Council of Churches, 1988; Beiser, 1988). This stress may result in emotional disorder. Pressure from the hosts may not be overt or even conscious; sometimes it is a grateful refugee's perception that he or she is expected to convert that creates the stress, rather than anything the host has said or done.

Other situations also generate stress. Refugees often perceive their sponsors as being overly intrusive in their family lives, even though sponsors may believe they are only being helpful. Despite the potential problems, hosting and sponsorship can be potent forces in preventing emotional disorder. Some studies have demonstrated that sponsorships which turn into prolonged friendships benefit mental health.

Some of the Refugee Host Group programs of CEIC provide information to sensitize hosts to the needs and the culture of newcomers, but such information is needed to guide the generosity of all hosts as well as sponsors.

The Ethno-cultural Community

As the New Brunswick Multicultural Council noted, local ethnic communities not only provide a welcome in an unfamiliar land but also "help to replace the lost familial and social networks so important to mental balance." Ethno-cultural communities provide some of the practical assistance and psychological support which extended families provide in traditional cultures and which service agencies provide in Canada.

Research has repeatedly demonstrated that immigrants and refugees who settle in an area where their ethnic group has already established a significant community experience lower levels of distress, and are much less likely to be hospitalized for mental disorder than migrants who do not have a like-ethnic community available to them. The psychosocial support provided by an ethnic community is particularly crucial during the early phases of resettlement.

The UBC Refugee Resettlement study compared rates of depression among ethnic Chinese refugees settling in Vancouver, which has a long established Chinese community, to Vietnamese and Laotian who had to establish their own cultural group on arrival. Vietnamese and Laotians experienced a risk of developing a depressive disorder three times greater than the Chinese (Beiser, 1988).

> *For the Southeast Asian people, community is the second most important social unit after the family. The informal community supports to all members in everything they do is the difference between Southeast Asian community support and the institutional support system.*
> *(Submission: S.E.A.R.C.O.M.)*

An important feature of viable communities is the numerical balance between males and females. Some immigrant communities are characterized by a significant imbalance between the sexes. For example, almost twice as many men as women have emigrated from Ethiopia since 1980. During the same period, females from Jamaica consistently outnumbered males. The mental health implications of such "unnatural" communities vary depending on the marital status, cultural background and economic situation of the individuals involved. However, priority should be given to applications for family reunification made by members of unnatural or imbalanced communities.

While ethnic communities provide practical assistance to newcomers, research evidence suggests that they help to protect mental health mainly by affirming cultural and personal identity. Religious institutions, for instance, reinforce personal faith which can act as a buffer to stress (Submission: Immigrant Women's Group of P.E.I.). Speaking one's mother tongue relieves the strain and exhaustion of constantly translating. Simple recreational and cultural activities enable immigrants to "let go" and "be themselves."

> *Since last year we have been running a club with some facilities where our people get together and socialize themselves. We have also organized and co-ordinate some programs that we think are very important for our people: Eritrean language school, that is to teach our children Tigrigna language [and] soccer team which is registered with Manitoba Soccer League and Soccer Association. We organized a cultural group which helps us to maintain our culture and participate in cultural events.*
> *(Submission: Eritrean Community in Winnipeg, Inc.)*

Where viable ethnic communities do not exist, immigrants and service agencies may be particularly challenged by the problems of settlement and adaptation.

Encouraging and fostering self-help and community leadership are important initiatives. Within any ethno-cultural group there are individuals with leadership capabilities and, in some instances, these people emerge spontaneously to guide and counsel community members.

> *Initially, most activities were worker-directed. However over time, some individuals themselves have initiated activities and provided leadership, so that presently the community is assuming more responsibility and the groups resemble a self-help model rather than a social work directed educational and therapeutic mode.*
> *(Submission: Catholic Immigration Bureau, Archdiocese of Toronto)*

While leadership sometimes emerges naturally, it can also be fostered through training programs which encourage and utilize innate skills (Submission: Inter-Church Committee for Refugees). Many programs described in Chapter Six depend on the leadership of ethno-cultural group members.

The Multiculturalism Sector of the Department of the Secretary of State contributes positively to the formation of support systems, ethnic organizations and leadership by funding multicultural social programs, ethno-specific cultural activities, heritage language programs and visible minority cultural development projects. Federal funding in this area is flexible and generous, with special consideration given to immigrant women's groups, children and youth. The Task Force encourages continuing funding of these programs, and urges that such support become more available to recent and less organized minority groups.

Canada's multiculturalism policy, which emphasizes opportunities for integration with the larger society as well as the enhancement of cultural heritage, endorses a principle and at the same time suggests actions important for mental health. While people from the same ethnic background often live in the same neighbourhoods, shop at the same stores, send their children to the same schools and attend the same churches because living together imparts a feeling of mutual support, this can, in the extreme, lead to isolation from the language, the institutions and the opportunities of the larger society. Isolation can in turn create a condition of risk for mental health. Programs to facilitate the development of ethnic communities should be developed hand-in-hand with others which encourage interaction with all aspects of Canadian society.

Services Aiding Settlement

Pre-migration orientation and settlement services can help to reduce stress and facilitate adaptation.

Pre-migration orientation is called for by immigrants, service agencies and government departments, as well as by the research literature.

> *The host country, in this case Canada, must be prepared to offer ample, accurate information regarding its social, economic and cultural conditions to the immigrant/refugee prior to actual migration. Greater knowledge of Canadian laws, services and the workings of the bureaucracy would relieve anxiety and encourage more realistic expectations.*
> *(Submission: New Brunswick Multicultural Council)*

Some efforts to provide pre-migration orientation are underway. A Polish-language videotape and brochure have been produced by CEIC in collaboration with Polish immigrants and distributed abroad for prospective Polish immigrants. A similar program for Central and South Americans is in the early stages of development. A pilot project in Thailand, funded by CEIC through the Mennonite Central Committee, provides orientation, language training and some skills training.

In addition to providing orientation materials in the languages of persons seeking immigration, CEIC is also encouraged to consider language skills when hiring, placing or transferring officers at home and abroad. Since CEIC officials are often the first Canadians that immigrants meet, it is particularly important that, regardless of language ability, they have enough cultural awareness and sensitivity to be fair — and to be perceived as fair — by the persons they interview. Cultural sensitivity training currently provided to officers should be evaluated by CEIC in collaboration with professionals from the fields of cross-cultural communications, adult education and immigrant settlement.

Immigrant settlement services constitute "a bridge to the mainstream or host society whose efforts deeply affect the settlement, adaptation and long-term participation of immigrants and refugees" in Canada (Submission: Alberta Association of Immigrant Serving Agencies).

The Task Force received numerous descriptions of the welcome, orientation, interpreting and advice provided by service agency staff, many of whom are immigrants themselves. As with ethno-cultural communities, immigrant service agencies also play a major role in providing support for people who develop mental health problems (Chapter Six). Their assistance during settlement, however, is immeasurably valuable in promoting mental health and well-being "even for those who are functioning optimally in Canada" (Submission: Edmonton Immigrant Services Association).

Agencies and ethnic communities across Canada were unanimous in calling for increased recognition of settlement services.

> *Organizations need more support to do outreach, to create programs that will be supportive from the beginning.*
> *(Submission: Woodgreen Red Door Family Shelter, Refugee Referral Office and Refugee Housing Unit)*

> *Settlement process is not of equal length for all immigrants and refugees, and therefore funding must reflect the full extent of need.*
> *(Submission: South East Asian Service (S.E.A.S.) Centre)*

> *To build an immigration policy without the necessary maintenance and supportive services behind it is to add fuel to a smoldering problem, and sabotages any long-range future goals for preventive psycho-social service care.*
> *(Submission: Centre Portugais de Référence et Promotion Sociale)*

Much of the funding for settlement services comes from CEIC's Immigrant Settlement and Adaptation Program (ISAP). Since fiscal year 1983/84, ISAP funding has increased from $3.14 million to $5.9 million. However, CEIC steadfastly refuses to provide direct "core" funding for the agencies which deliver the services. In one respect, the distinction is academic; if ISAP withdrew its funds-for-services, a majority of immigrant service agencies would collapse. In another respect, however, the official CEIC policy has serious consequences. The time spent applying for and reporting about multiple, short-lived programs and the year-to-year anxiety about funding exact a wasteful toll on both staff and clients.

Table 2.1 documents funding for migrant services in the top five immigrant-receiving provinces for the year 1986. The Table documents gross inequities in spending to support immigrant services: from a high of $226 per immigrant in Manitoba to a low of $8.76 per immigrant in B.C. Some provinces, such as Alberta, work closely with the federal government to support settlement agencies. Other provinces, such as British Columbia, are outspokenly reluctant to fund services which, they argue, fall under federal jurisdiction. Contributions from municipal governments also vary depending on the number of immigrants in a city and the number of immigrant-related problems brought to municipal attention. As one submission asserted, municipal funding tends to be remedial rather than preventive.

Table 2.1

Financial Support to Immigrant Services By Top Five Immigrant-Receiving Provinces*

Canada 1986

	Provincial Dollars (approx.)	Immigrants Received	Per Immigrant Expenditure	Total Population	Per Capita Contribution
Manitoba	$ 850,000	3,749	$ 226.73	1,071,232	$ .79
Québec	$ 2,500,000	19,475	$ 128.37	6,540,276	$ .38
Alberta	$ 1,200,000	9,677	$ 124.00	2,375,278	$ .50
Ontario	$ 4,700,000	49,663	$ 94.64	9,113,515	$ .52
B.C.	$ 110,000	12,556	$ 8.76	2,889,207	$ .04

Adapted from "Cultures West" (Newsletter of the Affiliation of Multicultural Societies and Service Agencies of B.C.), 5(4):3.

The question of exclusive jurisdiction versus federal-provincial cooperation has more than just political and short-term budgetary implications.

> *[Settlement] services must be strengthened, and immigrants should be followed up for a period of time so that they do not "fall between the cracks" of different service systems. A close working relationship between settlement workers and provincial health and social services program workers must be strongly encouraged.*
> *(Submission: Immigrant Women's Association of Manitoba, Inc.)*

Cooperation between federal and provincial governments regarding settlement services promises better mental health for immigrants, and long-term savings for provincial ministries.

Provincial health and social services have an important role to play in immigrant settlement and adaptation. The same should apply at the federal level. Health and Welfare, as well as CEIC and the Secretary of State, should assume responsibility for the well-being of newcomers. At the moment, Health and Welfare has limited involvement.

Health and Welfare Canada and its provincial counterparts could contribute to the health and well-being of newcomers in a number of ways. Those who have not received a pre-migration physical examination by a Health and Welfare physician should, upon arrival, be assessed by a physician. This initiative should be supported by appropriate government ministries. Psychosocial assessments, preferably carried out by qualified staff at immigrant service agencies and funded through Health and Welfare or appropriate provincial counterparts, should be carried out for all immigrants soon after arrival (Chapter Six). Medical and dental care for refugees should be extended to encompass more than the emergency and acute situations presently covered.

The sections on Remedial Measures and Special Needs suggest other ways in which Health and Welfare could contribute to immigrant well-being.

Conclusions

Ensuring adequate and stable funding for immigrant service agencies, promoting prompt and inclusive family reunification, and providing effective pre-migration orientation are three of the most important ways to facilitate adaptation.

The central role of immigrant service agencies during resettlement must be recognized since unstable and insecure funding erode their effectiveness. The Task Force recommends that **CEIC, Health and Welfare, and Secretary of State provide core funding to immigrant service agencies to guarantee their maintenance on a long-term basis**. Core-funding for agencies should be tied to the number of immigrants already living in an area as well as to the number of new arrivals. Short-term funding should be available for pilot projects and specific services meeting short-term needs. The settlement services provided by immigrant service agencies can be cost-effectively supplemented by, for example, educating hosts and sponsors of refugees and immigrants about the resettlement process, or by extending the time period over which informal (non-monetary) support is provided.

Along with refugee status, family reunification must continue to be given the highest priority as grounds for admission to Canada. It is recommended that **CEIC expedite changes in admission criteria to accommodate a broader definition of family, and changes in admission procedures to accelerate the process of family reunification**. The financial criteria for co-sponsorship agreements should be assessed and consideration given to expanding the program.

Migrants with little or no family in Canada must not be forgotten. Programs in which immigrants and refugees with few relatives are matched with families of similar ethno-cultural background should be encouraged if such matching is consistent with migrants' wishes. Refugees could be directed to destinations where there are appropriate ethno-cultural communities. Where such communities do not exist, their development should be encouraged through the cultural maintenance programs currently funded by Secretary of State. These programs, particularly those focussing on leadership training, should be expanded. Hosting and co-sponsorship should be encouraged and monitored. Hosts and co-sponsors should receive appropriate orientation to the culture of the newcomers they are helping as well as to the experience of resettlement and how their actions may influence the new settlers' mental health. To perform their important task, hosts and co-sponsors may require guidance; back-up resources must be available for this purpose.

Pre-migration orientation represents a relatively new idea, perhaps even a "high-risk, high-potential" venture. Much of the orienting done by immigrant service agencies could be simplified and the time spent in counselling immigrants experiencing stress due to acculturation could be reduced if pre-migration orientation were offered. The Task Force recommends, therefore, that **CEIC develop a multilingual series of pre-migration orientation programs in collaboration with immigrant service agencies and ethno-cultural organizations for dissemination in refugee camps and at Canadian embassies abroad.** Topics addressed should include employment, housing, schooling, climate, language training, psychological adaptation and social and cultural relations.

Chapter 3:

Official Language Education

The Issue

Without language, one can never truly enter a culture.

More than 30 presentations to the Task Force dealt with problems arising from lack of language proficiency. "It is the sense of being a 'marginal' person in society rather than a fully participating individual that directly contributes to a great number of health and social problems" (Submission: Immigrant Women's Association of Manitoba, Inc.).

Besides the isolation and loneliness it imposes, lack of language has indirect effects on mental health. Settlers in Canada who cannot speak English or French are less likely to find employment than those who do (Chapter Four). Newcomers who, despite their language handicap, succeed in finding a job, are likely to be underemployed, working at a level below that expected of persons with their level of training. Both unemployment and underemployment are risk factors for mental health.

Migrants who lack language proficiency suffer double jeopardy. While more likely to develop mental health problems than their English- or French-speaking counterparts, they also derive less benefit from the mental health care system (Chapter Five). They are less likely to make use of mental health services and, if they do seek treatment, are more likely to terminate prematurely or to experience an unsatisfactory outcome.

While many language programs exist for immigrants and refugees, restrictive criteria prevent some people from participating. Other problems, including inflexible class scheduling and funding instability, militate against the potential contribution of these programs.

Scope of the Problem

During the past decade, an average of 43 per cent of all immigrants arriving in Canada in a given year have spoken neither English nor French.

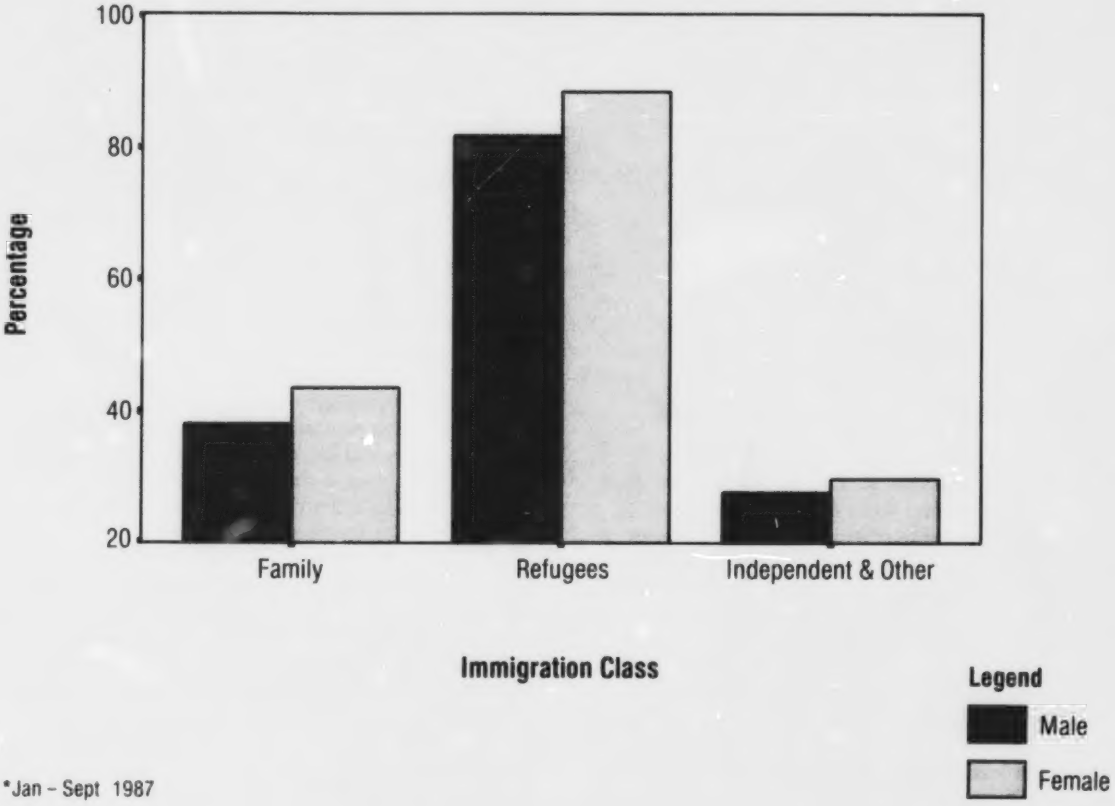
As illustrated in Figure 3.1, refugees are less likely to speak one of Canada's official languages than family class or independent immigrants. On the whole, more women than men arrive in Canada speaking neither English nor French.

The extent of the problem varies from province to province. More than half the immigrants destined for Manitoba between 1979 and 1986 had no capacity in English or French (Consultation: Manitoba Provincial Immigration and Settlement).

Figure 3.1

Percentage of Male and Female Immigrants in Each Immigration Class Who Speak Neither Official Language

Canada 1978-1987*



*Jan – Sept 1987

While, on average, the proportion of non-English speakers has tended to remain constant among arrivals to Canada, it has steadily increased in Alberta.

> ***Immigrants arriving without any knowledge of English has increased from 40 per cent in 1982 to 53 per cent in 1983, and to 61.4 per cent in 1984. Among refugees in recent years, approximately 85 per cent had no knowledge of English prior to arrival. In addition, many immigrants listed on immigration statistics as knowing English need further English instruction before being able to function in the job market.***
> ***(Submission: Alberta Immigration and Settlement Services)***

Current Policies

The *British North America Act* defines education as a provincial matter. Federal responsibility for immigrant language training is, therefore, discharged through federal/provincial arrangements.

Federally funded language training programs for immigrants (ESL/FSL — English as a Second Language/French as a Second Language) are presently administered by the Department of the Secretary of State and CEIC.

1. CEIC Labour Market Access Language Training

Under the Job Entry component of the Canadian Job Strategy, CEIC provides language training for adult migrants and native Canadians who cannot find employment in their usual or related occupations due to a lack of proficiency in one of the official languages.

Training seats constitute the basic mechanism through which the federal government provides for language instruction. The federal government purchases training seats from the provinces and from private institutions according to priorities set by needs assessment committees. Language instruction is then provided by instructors hired by the provinces. Training is usually full time; basic living allowances or unemployment insurance benefits are provided to trainees who meet certain criteria. Members of the Family Class and Assisted Relatives, while eligible for training, do not receive the basic training allowance. They can, however, receive supplementary allowances for child care, living away from home expenses, and community expenses.

In response to the large refugee movements of recent years, the scope of language training has increased. In 1978, there were 2,000 training seats; in 1987, more than 14,000. Eligibility criteria have also expanded to include unskilled workers who are unable to secure employment or to undertake vocational training without language training.

2. CEIC Skills Language Training

Certain projects for immigrants, funded under the Job Entry, Job Re-entry, and Job Development programs of the CEIC, also provide a component of language education. This type of language training is not considered an alternative to full-time training; it is seen as an adjunct for immigrants who must achieve a higher level of fluency or who need a good working knowledge of a specific occupational terminology.

3. CEIC Settlement Language Training

In 1986/87, CEIC funded the Settlement Language Training Program (SLTP), a pilot project designed to meet the needs of adult immigrants — primarily women — who are not destined for the labour force. The program format was flexible; on-site child care was available and out-of-pocket expenses were reimbursed where need was indicated. SLTP funding has again been allocated for 1987/88, but only at the pilot project level of $1 million.

4. Secretary of State Citizenship and Language Training (CILT)

With the exception of New Brunswick, all provinces and both territories have signed Citizenship and Language Training (CILT) agreements with the federal government. Under CILT agreements, Secretary of State pays half the salaries of instructors engaged in language training for individuals intending to acquire citizenship. Training is part time and no allowances are provided. In addition, Secretary of State reimburses provinces up to 100 per cent of the costs they incur for printed materials used in language training.

5. Secretary of State Citizenship and Community Participation Program (CCPP)

Some language instruction is included in the Citizenship and Community Participation Program (CCPP) funded by Secretary of State. CCPP replaces the Cultural Integration Program once funded by the Multiculturalism Directorate.

Problem Areas

Restrictive eligibility criteria constitutes the most serious limitation of federally funded language training programs.

Since current policy dictates a focus on migrants destined for the labour market, many immigrant women and seniors are cut off from language training programs, particularly those falling under the Canadian Job Strategy initiative. In 1986, 87 per cent of immigrant men, but only 49 per cent of immigrant women, were identified as labour-force bound and thereby eligible for CJS training allowances.

The SLTP pilot project, aimed at meeting the language needs of non-workers, has had very positive results, particularly among immigrant women. As the Association for New Canadians reported, SLTP offers "invaluable assistance" for those immigrants who will not be entering the work force, but who must have a functional grasp of the language they hear all around them.

Inadequate and inconsistent assessment and referral practices plague language training programs, even for those immigrants who are eligible for them.

Migrants' personal backgrounds, learning goals and settlement needs are frequently overlooked during assessment. Course placements are often made by officials who cannot communicate with the clients, yet the complexity of the training options (different entrance requirements, non-standardized criteria for transfers) make it virtually impossible for immigrants to plan their education themselves.

The assistance and advice immigrants receive appears to vary from region to region and, in some cases, from counsellor to counsellor. Access to language training may or may not be restricted to one family member. Unemployed immigrants may or may not be advised that they need to speak English or French in order to find "suitable" employment.

Language training must be preceded by professional, holistic assessment and individual client counselling. The Teachers of English as a Second Language (TESL Canada, 1982) have recommended the establishment of counselling centres where sensitive assessments and consistent, fully informed referrals can be made. Catholic Social Services of Edmonton and Calgary Immigrant Aid, both provincially funded language and vocational assessment centres, provide valuable models for implementing this recommendation.

Lack of coordination in program planning has resulted in an inefficient and sometimes wasteful use of resources. While some programs are forced to turn away eligible applicants, other language training components are under-utilized.

Language training is delivered in a myriad of formats, ranging from full-time institutionalized programs of 36 weeks to volunteer classes or home tutoring of relatively short duration. Program content is just as varied, depending as it does on the funding source, the clientele for which it was originally developed and the individual instructor.

The problem is not with program variation per se, but that it usually lacks overall planning and purpose. In fact, there is a need for even greater flexibility in program format and content, but flexibility which responds to the educational background, situational needs and personal aspirations of the clientele:

- The time and location of classes must be flexible, whether morning, evening or during the lunch hour at the workplace.
- Existing vocational training programs could be enhanced by CEIC and relevant provincial ministries by incorporating language training components.
- There should also be a "cross fertilization of purpose" in all training, for example, ESL/FSL could be incorporated with the teaching of parenting or lifeskills.

- Language training programs must be flexible in the level of language difficulty; for example, instruction could range from basic "survival language" for newcomers during early phases of resettlement to more advanced language training for professions.

The province of Quebec's language-training tracks, which are tailored to meet individual needs and goals, provide a valuable model which might be emulated elsewhere.

The federal government must ultimately take more responsibility for ensuring the efficacy of the language training programs it funds.

> *Standards of success in ESL should be related to the immigrant's ability to function in the community, to access services and to solve problems for themselves. This means greater flexibility in approach, in methodologies, and in the length of time ESL courses are offered. As well, the provinces should be made accountable for their expenditures of transfer payments on ESL programs, materials, etc., and encouraged to support more innovative Second Language programs.*
> *(Submission: Centre for Research and Education in Human Services and Kitchener-Waterloo Refugee Co-ordinating Committee)*

By assuming or delegating a coordinating role, the federal government could ensure that existing language training opportunities are fully utilized, that successful, innovative program ideas are shared among institutions serving similar populations, and that the dollars expended on language training result in language acquisition.

Instability in funding makes it extremely difficult for program administrators to attract, develop and retain qualified staff.

Depending on the funding, instructors delivering language training vary from persons without formal qualifications to those with post-graduate degrees in education. Programs with relatively stable, adequate funding naturally attract better qualified instructors. More importantly, these instructors remain and pass on to clients the benefits of first-hand experience and skills learned on the job.

As several submissions noted, skills learned by teachers on the job are critical for the adaptation and integration of their students.

> *The work of the educator can be reconceptualized from that of language trainer to that of settlement educator. Instead of seeing the immigrant primarily as a stranger who does not know our language and customs, we can choose to see her or him as a newly arrived member of our human community who has chosen to join us in creating a better society for everyone who lives here. We need to see the immigrant learner less for what is lacking and more for what is present.*
> *(Submission: Sauvé)*

Qualifications of Language Instructors: Because they are respected persons who come into contact with migrants during the early phases of resettlement, ESL/FSL teachers are sometimes looked to as counsellors and advisers as well as language instructors. They are, therefore, in a good position to identify migrants who are at risk for developing emotional disorder.

Before ESL/FSL teachers can perform their principal task, imparting language, in an optimal fashion, let alone adding the new responsibility of acting as gate-keepers for mental health, a number of steps must be taken. Teachers should receive formal accreditation and recognition commensurate with their qualifications and experience. Standards should be established by provincial ministries responsible for education with the encouragement of CEIC and Secretary of State. ESL/FSL teachers should be trained to identify signs of emotional distress and how to make appropriate referrals. Mental health consultation must be available on an ongoing basis.

Stable funding must be provided to enhance the efficacy of language training by enabling administrators as well as instructors to improve programs on the basis of experience. At present, evaluations of many language programs are never utilized because the programs themselves are so short-lived.

Finally, with dependable funding, meaningful research can be undertaken and the results fed back into the programs on which they are based. Such questions as how to best teach job-specific language, or how persons illiterate in their mother tongue can best learn a second language, need to be answered by empirical data derived from stable language training programs.

Conclusions

All immigrants should have equal access to official language education according to need, so they can integrate with and contribute to Canadian society.

It is recommended that **CEIC enable all immigrants and refugees to have equal access to official language education whether or not they are destined for the labour market.**

Basic training allowances must be available regardless of the immigration class of training applicants.

The number of training seats purchased in each province should be commensurate with long-standing needs of immigrants as well as with current levels of immigration.

Flexible arrangements should be available to ensure appropriate care of children while parents are attending language training programs.

There is also a need for the programs themselves to be varied in scope and format.

The Task Force recommends that **CEIC, in coordination with Secretary of State, expand and ensure the flexibility of official language training programs with respect to the level of mastery assumed, objectives of course content, duration of program, scheduling of instructional hours and location of classes.**

Chapter 4:

Employment

The Issue

People work in order to make a living. However, in an achievement-oriented society such as Canada's, work also possesses important symbolic value: being a person of worth depends on being a productive, contributing member of society. Because self-esteem, the way we see ourselves, is a reflection of the way we are perceived by others, people who do not or cannot work often feel unworthy. This threat to self-esteem makes people vulnerable to developing emotional disorder. Increased rates of depression, alcoholism and suicide during periods of economic recession or among people who lose their jobs because of local economic dislocations are powerful evidence of the damaging psychological effect of unemployment. Unemployment affects other people besides the one who cannot find a job. Families in which the head of the household is unemployed suffer an increased frequency of child abuse, wife-battering and marriage breakdown.

Although unemployment poses a risk of psychological problems for everyone, immigrants and refugees are particularly vulnerable to this stressor. Changes in Canada's migration patterns have affected immigrants' participation in the labour force. Where this country once drew upon the United Kingdom, the United States and European countries for its labour needs, more recent waves of immigrants and refugees have brought workers from Asia, Africa, and Latin America (see Figure 0.3). Suitable entry to the labour force for this "new" immigrant is frequently delayed due to lack of training or work experience appropriate to the Canadian labour market. Typically the last to be hired and first to be fired, migrants suffer higher rates of unemployment than the general population. Barred from many jobs because of language difficulties, lack of training or discrimination in hiring practices, many migrants are forced into low-level jobs in which their marginal status makes them prone to exploitation. Highly educated and highly trained immigrants and refugees often find it impossible to work at the level for which their training has prepared them; the resulting underemployment is a potent risk factor for emotional disorder.

Besides the emotional suffering experienced by immigrants and refugees as a result of unemployment and underemployment, the host country is penalized. People who could and should become important resources for Canada must, too often, turn to public assistance. They also resort to the health care system because their marginal status damages their physical and emotional health.

Employment Prospects of Particular Groups

Unemployment, underemployment and job insecurity create chronic stress for many immigrants, particularly during periods of economic down-turn. Certain categories of immigrants are further disadvantaged in their struggle for employment because of their race, sex or age.

"Visible minority" immigrants, those whose racial features distinguish them from the majority of Canadians, experience the same discriminatory hiring practices that place Canadian-born visible minorities at a disadvantage in the job market. Measures to address racially based inequities and eliminate discrimination in the workplace are described in *Toward Equality* (1986), the response to the report of the Parliamentary Committee on Equality Rights, and also in the Abella Report (1982).

Immigrant youth often face obstacles to employment that go beyond those faced by either Canadian-born youth or by immigrant adults. Chapter Nine discusses the implications of disrupted schooling and language disability for the employment prospects of immigrant adolescents.

Immigrant women are not only subject to the inequities affecting Canadian-born women in the labour force; many are also destined to marginal employment because they enter the country as Family Class members and are, therefore, considered by many employment counsellors to have had little or no work experience outside the home. The implications of this status for employment opportunities and hence for the mental health of immigrant women are discussed in Chapter Ten.

Older immigrants who do not have jobs waiting for them are less likely to find employment than are younger adult immigrants or Canadian-born persons of similar age. Since increased age also affects ability to learn a new language or adapt to a new culture, older immigrants, as noted in Chapter Eleven, are vulnerable to stress-related health and mental health problems.

A disproportionate number of migrants who enter the work force do so through marginal types of employment, where standards and benefits vary considerably. Knowing little or nothing about Canadian law and often fearing that being fired means being deported, newcomers are vulnerable to exploitation.

Migrants who work as domestics or farm workers, for example, may be required to work longer hours and under more adverse conditions than would be tolerated in regulated industries, often for below minimum wage compensation. They are loathe to complain because they fear losing their jobs. Even if they were willing to complain, there frequently are no regulatory bodies to which they could appeal.

Immigrants working in high-risk industries such as mining and certain types of manufacturing may be in more jeopardy than their fellow Canadian workers because they do not fully understand safety instructions. Warning signs may be posted only in English and/or French. The implications of physical injury for mental health are obvious, and are compounded for many immigrants who are unaware of, or who cannot negotiate, the bureaucracy of workers' compensation.

There is a need for CEIC, in liaison with provincial ministries of labour, to review employment standards, occupational health and safety, and complaint procedures for domestic workers, farm workers and other occupations which employ immigrants and refugees.

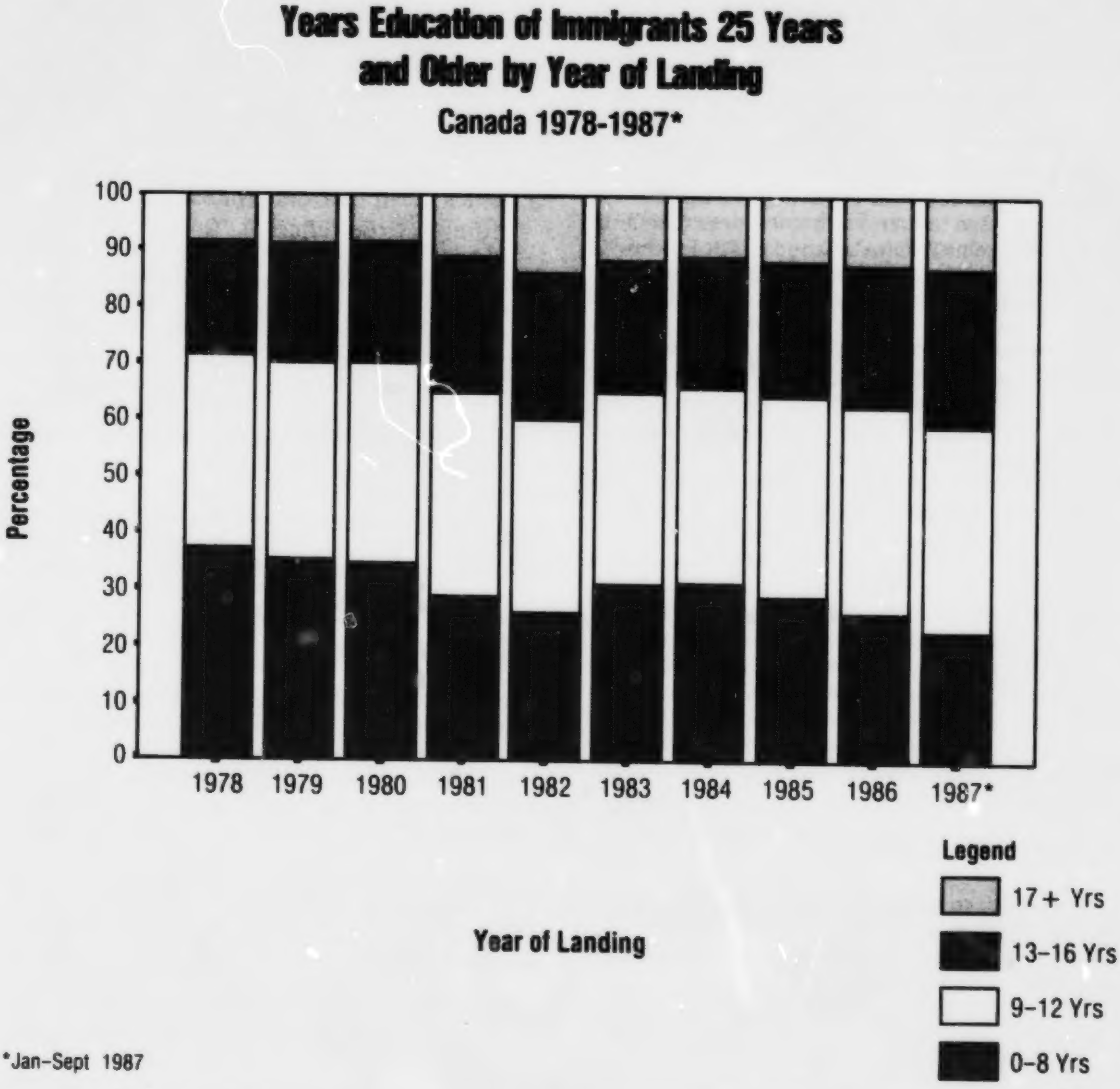
Underemployment of Immigrants and Refugees

Since, to a great extent, Canada's labour market needs dictate its immigration policies, persons who have been selected for immigration arrive with the expectation that they will be able to practise the occupation in which they have training and experience. Failure to realize these expectations results in frustration, alienation from a familiar working environment, erosion of skills and ultimate loss of human potential to the Canadian economy. In fact, occupational adaptation may well be more significant for mental health outcome than economic adaptation.

Canada can potentially benefit from an influx of people who have already been educated elsewhere. As Figure 4.1 illustrates, during the past decade, a third or more of all migrants to this country have been people with post-secondary educations. Unfortunately, many cannot or do not find employment at a level for which their education has equipped them. The negative impact of unfulfilled occupational expectations upon individuals with higher education or with technical or professional training was emphasized in numerous submissions.

> *Many trained and skilled newcomers to Canada are deprived from apprenticing or contributing to Canadian society to their maximum capacity. They are forced to take up menial jobs, not related to their skills, in order to be self-supporting... It is my understanding that contrary to popular belief, according to recent studies, stress-induced illnesses are more apt to strike workers at the bottom of the ladder than those at the top... It is my understanding that recent studies indicate that position in the job hierarchy, not just income, determine a person's health.*
> *(Submission: Kurol)*

Figure 4.1



*Jan–Sept 1987

Sexual stereotypes continue to make employment a particularly difficult problem for women.

> *Professional women immigrating to this country face stresses of their own... [They] suddenly find that the only work which is available to them is the unskilled sector, as Canadian universities and professional organizations do not recognize their foreign qualifications. This deprofessionalization gives an intensive shock to the women's self-esteem. For example, medical doctors are known to work as housekeepers in hospitals.*
> *(Submission: Alberta/NWT Network of Immigrant Women)*

The Calgary Catholic Immigration Society expressed concern about the psychological stresses their immigrant and refugee clients suffered because of lost social and occupational status. Immigrants and refugees with technical training who fail to achieve employment parity were found to be particularly vulnerable to the stresses of unemployment. Difficulties with failure to achieve satisfactory employment due to licensing barriers were described by the Immigrant Women's Group of P.E.I., who raised the question of whether Canadian licensing bodies over-emphasize licensing regulations.

Barriers to Trades and Professions

An intensive review of entry requirements to trades and professions was undertaken recently under the auspices of the Cabinet Committee on Race Relations, Province of Ontario (1987). This review attempted to identify the reasons why so many immigrants are unable to practise their chosen professions. While emphasizing the tentative nature of the findings, the authors suggested that systemic barriers with economic, cultural and administrative origins may have a disproportionate impact upon immigrants seeking entry to trades and professions in Ontario.

Among the more common barriers to access to trades and professions were:

1. Language proficiency

Lack of access to language training, inappropriate training modules, and lack of access to specific technical or professional language training have all been cited as obstructions.

The commonly used Test of English as a Foreign Language (based upon U.S. 1951 standards) has been challenged as being too stringent. Critics contend that the test over-emphasizes formal grammar while failing to place enough stress on proficiency in occupationally specific technical language.

2. Evaluation of academic credentials

Impartial evaluation of the credentials of foreign-trained immigrants is difficult to achieve. Evaluations are inevitably prey to subjectivity, hence to possible biases and to lack of understanding about educational equivalencies on the part of professional review panels. There is an ever-present danger that, in evaluating academic qualifications, professional societies may be moved to protect the interests of their current membership more than by the need to ensure parity. The result is that many migrants experience down-grading of their credentials.

3. Allocation of credit for foreign experience

Many trades and professions require proof of "Canadian experience" as an entry to practise. This places the foreign-trained in the difficult situation of not having the required experience yet being unable to secure employment where they might acquire it.

Discounting previous foreign experience due to lack of a certificate is a perceived barrier. Many foreign-trained skilled tradesmen are schooled under the apprenticeship system in countries that pay little attention to certification. Inability to produce documentation to support experience is a deterrent to entry to some trades.

4. Examinations

The number of times an applicant may write an exam is often limited. Some professions — nursing, accounting, law — do not permit those who have trained abroad to write certification exams until they have taken re-training. This poses economic and social difficulties. For many newcomers, the cost of re-training may be prohibitive. Mature practitioners who do gain access to training programs may be inappropriately placed with young, first-time learners in structured learning situations to which they have difficulty adjusting.

5. Systemic discrimination

Immigrants have alleged that the barriers preventing them from practising their trade or profession were deliberately created to exclude foreign-trained personnel. Others perceived discriminatory practices as being cultural or racist in origin.

6. Translation and interpreter services

The poor quality of translation of documents has been cited as one reason equivalencies are sometimes not granted. The lack of translation and interpreter services are viewed as barriers to access.

7. Practical Considerations

Many immigrants, particularly refugees, complain about the requirements for presenting original documents. Refugees may have lost their documents in flight or in refugee camps. Political upheaval in their home country may mean there is nowhere to appeal for replacements. Some foreign schools may no longer exist, may be difficult to locate, or may be uncooperative in responding to requests for transcripts. Many immigrants are frustrated by the delays and costs involved in acquiring papers by applying to their country of origin. Given all these difficulties, it is small wonder that many migrants who are fortunate enough to have documents are reluctant to surrender original copies to Canadian accreditation bodies.

In sum, criteria for qualifications for entry to trades and professions are established to set standards, regulate practices and balance the rate of entry to training with that of labour market needs. The regulatory practices of trade and professional organizations, based on Canadian educational and training standards, do not accommodate foreign-trained persons. Migrants whose educational backgrounds do not exactly match those of Canadian norms may require special consideration in order to qualify for certification or licensure in their intended occupations.

Before immigrants can qualify to practise their trade or profession, they must have access to training programs. Criteria for admission to these programs can be as restrictive as those of the trades and professions themselves. CEIC, in cooperation with the provincial ministries of education and of higher education, should work closely with training institutions to encourage more flexible and broader criteria for admission to training programs.

Adjudicating the credentials of foreign-trained persons is vulnerable to bias due to the subjectivity of the process employed. However, in the absence of more objective evaluative criteria and general lack of information about the relative equivalencies of foreign educational systems, discrepant decisions made on the part of professional organizations with respect to the applications of immigrants are not subject to challenge.

For those who persevere beyond the entry process, delays in obtaining equivalencies, requirements for re-training, demonstration of "Canadian experience," and financial considerations unreasonably extend the process. Prolonged alienation from the respective occupational environment leads to erosion of skills, loss of technical idiom and diminishing confidence in one's capabilities — all serving to widen the gap between the individual and attainment of his or her occupational goals.

Some recent governmental initiatives to address the needs of specific groups of immigrants and refugees have had notably successful results. In Quebec, the Division scolaire et professionelle of the Ministère des communautés culturelles et de l'immigration was concerned about the manpower wastage resulting from underemployment, and the psychological stress this creates for migrants not working at their level of achievement. Under its reorientation program, the division performs a number of functions for individual migrants including determining the North American equivalence of their diplomas, and arranging for special training that leads to up-grading and re-licensure. During their training, migrants may receive financial support from the Ministry.

Under Canadian Job Strategies Initiatives, approval has been given for the production of 26 half-hour television instructional segments in basic English under the joint sponsorship of CEIC and Secretary of State. It is hoped that the success of this project in Ontario will lead to similar programs being developed elsewhere in Canada.

The Task Force heard one particularly innovative suggestion: that CEIC consider providing a subsidy to employers to promote the hiring of one additional employee to offset an equivalent number of man-hours allocated to "on the job" language training for immigrants and refugees. An administrative fee associated with allied costs might serve as further incentive to employers to take advantage of such a pilot project. The net effect would be to generate employment both for the unemployed segment of the Canadian labour force and that of newcomers.

Employment Counselling

Sooner or later, most newcomers come into contact with an employment counsellor. Too often, these are unhappy experiences resulting in demoralization and lowered self-esteem. Migrants applying for job assistance are particularly vulnerable; they may interpret a brusque manner, a culturally insensitive remark, an offhand acknowledgement of some skill they have worked hard to achieve, as rejection of themselves and as evidence of racism. They are undoubtedly correct some of the time.

There is a need for the current cross-cultural orientation programs for employment counsellors to be thoroughly evaluated. This project should be undertaken in collaboration with professionals from the fields of cross-cultural communication, adult education and immigrant settlement. The evaluation should include measures of effectiveness, knowledge of course content and acquisition of culturally sensitive attitudes and behaviour. Performance appraisals should include these criteria.

CEIC should explore means of recruiting employment counsellors from ethnic communities. Heritage language ability and cultural sensitivity should be seen as assets in hiring decisions. These abilities should be taken into greater consideration when placing and transferring counsellors.

Conclusions

Canada's immigration policy is in part dictated by a motivation to admit well-trained, well-educated people who can contribute to our economy. If we admit people according to this principle, but fail to provide opportunities for them to exercise their skills, the result is a disservice both to individual and national interests. The process is wasteful of human talent and it may jeopardize mental health.

The Task Force recommends, therefore, that **CEIC, Ministry of Labour and Secretary of State enter into negotiations with their provincial counterparts to provide criteria and guidelines for entry into professions and trades by persons trained outside of Canada.**

Incentives to the private sector should be provided by CEIC for more immigrant and refugee on-the-job training positions, tied to employment equity programs. Equal employment opportunity policies in both private and public sectors should be promoted by Treasury Board in coordination with CEIC and Secretary of State. Information about existing policies and programs should be distributed.

Part III:

Remedial Measures

Chapter 5:	Formal Mental Health Care	37
Chapter 6:	Mental Health Care Outside the Formal Network	47
Chapter 7:	Training for Service Providers	53
Chapter 8:	Ethnic Practitioners	59

The mental health care system in Canada is a loose amalgam of services of two types: 1) those mandated to deliver mental health care and 2) those which, although organized for a different purpose, treat and rehabilitate people with mental disorders. **The formal mental health care network** is made up of mandated services: psychiatric hospitals, psychiatric wards in general hospitals, clinics, community mental health agencies, and mental health practitioners in private practice.

Other agencies also deliver mental health care, even though this may not be acknowledged or recognized by either the institution or its clients. People who are troubled often avoid formal mental health services, turning instead to family physicians or to family service counsellors, public health nurses, the staff of multicultural or ethnic community organizations, or second-language teachers. For example, of all contacts between majority culture patients and family physicians, 15 to 20 per cent involve a mental health problem. Although no data about the way immigrants and refugees use the health care system have appeared, there is no reason to believe that the proportion of time and effort taken up by psychiatric problems is any less than it is among the majority of Canadians. In this section, we refer to this de facto system of mental health care as **mental health care outside the formal network**.

Immigrants and refugees experience stress if they have suffered trauma before migration, or if, after migrating, their needs for social support, language capability, and meaningful employment have not been met. When this stress is combined with certain personal characteristics, emotional problems may result. Many migrants are reluctant to use formal mental health services, sometimes because of the stigma of mental disorder and sometimes because they doubt the benefits of treatments they cannot understand. If they do become clients, they are often dissatisfied with the treatment or terminate it prematurely. For example, 30 per cent of the people seen at mental health clinics drop out after the first interview; the corresponding figure for ethnic minorities is 50 per cent (Sue, 1977). The most common complaint is that mental health therapists do not provide culturally and linguistically appropriate treatment.

Immigrants and refugees often feel more comfortable with a worker from an ethnic organization — someone who speaks their language and shares their culture — or with an immigrant services worker with whom it may be possible to discuss problems without being labelled mentally ill. However, people who have been trained to help migrants find shelter and jobs, to learn one of the official languages, or to provide prenatal and well-baby care, are not mental health care providers. Their training has not prepared them to recognize mental health problems or how to deal with them.

Barriers to access and dissatisfaction with formal mental health care as well as the lack of expertise in the de facto care system result in tension between the two sectors of care which is difficult to resolve. Ideally, the strengths and weaknesses of each should be complementary. There are examples of effective integration which leads to improved care. However, the examples are isolated ones. In general, the formal and de facto sectors of care function in relative isolation from each other, rather than as components of an over-all system of care.

This section addresses questions and concerns about mental health care, staffing, and training. How can treatment be made more sensitive to the needs of newcomers and members of ethnic minorities? Should ethnic workers join the personnel of formal treatment agencies or is it preferable to attach mental health professionals to ethnic and/or community service organizations? Why are most immigrants and refugees so dissatisfied with the treatment they receive? Is the present non-comprehensive, non-integrated, non-system the best we can hope for? Or is it possible to develop new, more effective models for delivering services?

Concerns about the mental health service system include: the kinds of services that should be delivered; who should be trained to deliver these services; and what training should consist of. There are no easy answers. People who deliver specialized services for newcomers cannot become experts in diagnosing and treating mental illness, just as psychiatrists, psychologists, psychiatric nurses, and social workers cannot become experts in the cultures of all their clients.

The problem of combining cultural and linguistic knowledge with appropriate professional expertise is so acute that failure to make use of people who combine these skills is a waste of resources. The Task Force frequently heard about immigrant and refugee mental health professionals who, because of licensure and practice restrictions, may never be able to utilize their skills in Canada, and about immigration policies which restrict the flow of such personnel into Canada.

Fortunately, the Task Force also heard other messages: about experimental models for providing care which seem to be working; training programs to develop personnel who may help knit the disparate strands of mental health services into a better system of care; and ways to ease the frustration and overcome the loss to society of underemployed professionals.

Chapter 5:

Formal Mental Health Care

The Issue

At most, only 20 per cent of people with mental disorders who need care actually receive it somewhere in the formal mental health system. While underutilization of services is a general problem, immigrants and refugees resist mental health care even more than majority culture Canadians. Ethnic groups in Canada avoid the mental health system because they feel that barriers impeding access to appropriate services are often insurmountable. They also feel that, even if they sometimes succeed in overcoming barriers, the treatment they receive is inappropriate or ineffective. These feelings are not confined to small communities or to recent arrivals. Large cultural groups who have been in Canada for generations also feel disenfranchised from care.

Barriers to Care

While symptoms of emotional disorder are remarkably similar throughout cultural groups, culture dictates how people perceive and respond to them. For example, depression is one of the most common of all emotional disorders and one of the most debilitating. Depending on cultural background, a person suffering from depression may try to ignore it, accept his or her suffering as fate, talk to a religious leader, seek treatment from a folk healer, discuss the problem with family, or consult a family physician.

Primary care physicians are an important community resource for treating persons with emotional problems or referring them to the mental health care system. However, their effectiveness is compromised by cultural factors. Even though primary care physicians help many persons suffering a depressive disorder, they fail to recognize these illnesses in as many as two-thirds of their patients. The problem is even more acute among their ethnic clientele. One reason is that people — knowingly or unknowingly — conceal their symptoms. In Asian cultures, it is unacceptable to complain to a doctor about feeling despondent, lonely, or suicidal. Chinese, Vietnamese, Laotian and Cambodian patients will concentrate instead on the physical symptoms of depression such as sleeplessness, weight loss, appetite disturbance and pain, all of which are considered more legitimate reasons to seek medical help. The result may be a misdiagnosis or a missed opportunity to refer someone for mental health care.

Even when a referral is recommended, people are reluctant to comply. Feelings of shame and fear of being stigmatized are potent reasons for resisting referrals.

> *The majority [of persons in care] would have been brought to the institution by the police after some incident where they have gone "haywire." Such patients often receive little support from friends and families. The stigma attached to being "crazy" or "mad" is one that does not change easily even among the more educated and better informed members of the black community. Patients and their relatives would prefer to be labelled as "bad" rather than "mad." In some sectors of the community, treatment for mental illness lies in a "good bath" to cure the ailment which is diagnosed as the consequence of fate, heredity, or supernatural forces like obeah.*
> *(Submission: Harambee Centres Canada)*

Lack of information and misinformation about services also account for underutilization. A common fear is that one's immigration status can be jeopardized if he or she is found to have psychological problems.

> *The family delayed hospitalizing the patient because of the fear of deportation associated with mental illness. There was also an implicit fear that this would stigmatize the whole community and restrict immigration from that particular country.*
> *(Submission: Saskatoon Open Door Society)*

Inability to pay is another barrier to getting needed help.

> *It has been found that where a person is referred to a psychologist by a medical doctor that the Medical Services Insurance (MSI) system will not provide coverage; it only covers for psychiatrists.... Therefore, there is no treatment available since the individual is in the process of establishing himself and cannot afford to pay for the services himself.*
> *(Submission: Metropolitan Immigrant Settlement Association)*

> *In Saskatoon, immigrant clients can only be sent to the community clinic for counselling, and that institution is dealing with an overload of clients. We are aware of counsellors in private practice, with cross-cultural sensitivity that can do effective counselling, but there is no way that they can currently be referred to them.*
> *(Submission: Saskatoon Open Door Society)*

Part of the difficulty in getting people into appropriate care may stem from the extreme specialization which characterizes Canadian society, where mental health services are separate from other aspects of life, including general medical care.

> *Because of the interrelationship of mental and physical health, and because of the particular medical needs of the refugees, it is recommended that these two services be provided together, in one building as one organization. Referrals to different organizations should be kept to a minimum, especially as the process of referral is very costly, time-consuming and confusing to the refugee.*
> *(Submission: Edmonton Immigrant Services Association)*

Better mental health care programs for immigrants and refugees do exist. The American Psychiatric Association recently awarded a gold medal for innovative service to a successful mental health service for Indo-Chinese refugees, operating for a number of years in Portland, Oregon. Close integration of the mental health clinic with a community centre for Southeast Asian refugees undoubtedly accounts in part for the creation of large clientele. Refugees enter the treatment system with an ease which belies the stereotype that Asians resist mental health care, no matter how necessary it might be.

Hospitals are particularly likely to be isolated from communities. The isolation is more than physical. Since most hospitals do not have specific policies regarding immigrants and refugees, their staffing patterns, hiring practices, training programs and physical facilities often fail to reflect the multicultural diversity of their patients. Lacking appropriate training and resources such as interpreters, hospital personnel frequently perceive migrant patients as troublesome and unrewarding.

Overcoming Barriers to Entering Care

Public education is one way to promote the appropriate use of formal mental health services. Many submissions which discussed the problem of underutilization of services urged that educational materials be developed, translated and disseminated.

> *Translations of culturally appropriate materials are needed to increase understanding of such problems as depression, paranoid symptoms, intergenerational conflicts and identity crises. Such materials could help to counter traditionally held feelings of shame and guilt about mental illness in the family and promote earlier help-seeking. Articles and media presentations making it more acceptable to seek help early, and identifying "at risk" behaviours should be encouraged in ethnic press, radio and television outlets, as well as through the church and other valued agencies in ethnic communities.*
> *(Submission: British Columbia Association of Social Workers, Multicultural Concerns Committee)*

Effective educational materials share a number of common features:

- use of pictures as much as, or more than, words, "like UNICEF programs on health for Third World countries". (Submission: Centre Portugais de Référence et Promotion Sociale)
- use of ethnic media, particularly television and radio, rather than general community media. For example, a series of programs on mental health was recently produced in Japanese for Vancouver's Multicultural Channel. (Submission: Japanese Community Volunteers' Association)
- use of immigrant service agencies as much as, or more than, general community agencies for disseminating printed materials.

Outreach materials should address at least three topics: what mental illness is and how to recognize it; what mental health care is like and why it is offered; and how to gain access to local mental health services. As discussed in more detail in Chapter Six, multilingual information about the psychological effects of migration, settlement, and acculturation has also proven helpful.

In some large urban areas, mental health education personally delivered to community groups by multicultural or ethno-specific health workers has been effective.

> *Community outreach education is one of the strategies used by Hong Fook to reduce negative attitudes towards mental health ... We spend considerable energy on organizing community forums, developing resource materials such as educational pamphlets and slide-tape shows, and participation in community functions such as senior health fair and Southeast Asian festival of health. The two part-time community education workers responsible for these educational activities are funded by a project grant from the Secretary of State.*
> *(Submission: Hong Fook Mental Health Association)*

The more personalized the delivery of mental health outreach services, the greater their effect in increasing the use of mental health remedial services. As the Southeast Asian Service Centre (Toronto) notes, for immigrants and refugees in stressful situations to use appropriate mental health services, "a labour intensive, one-to-one outreach is often required."

Why Services are Sometimes Inappropriate or Ineffective

Cultural and language barriers may be responsible for incorrect assessments and for treatment difficulties.

Ethno-cultural groups and service providers agree that lack of common language is the barrier which interferes most with assessment as well as treatment. As a submission from M.O.S.A.I.C. in Vancouver notes, "We speak to our emotional needs and describe traumatic experiences in our first language." Yet many treatment agencies are staffed entirely by people who cannot speak to newcomers in their first language.

Assessment, during which a therapist makes a judgement about a client and arrives at a conclusion regarding his or her psychiatric status, is subject to potential bias of many types. One study found that when therapists routinely interviewed patients, they tended to assign diagnoses of depression more often to whites and of schizophrenia to blacks. When they used a standardized interview form, differences between blacks and whites disappeared. The implication of these findings is that, in day-to-day clinical practice, therapists may fail to collect all the information relevant to making a diagnosis. Cultural stereotyping may lead to inappropriate short-cuts in data-gathering. Southeast Asians typically will not volunteer that they are feeling depressed, a phenomenon which has led many clinicians to speculate that when Asians become psychiatrically disturbed, their illness experience is different from Caucasians. However, research has demonstrated that despite their reluctance to volunteer their depressed feelings to physicians, Asians have an extensive vocabulary for depression and, if asked, will report these feelings.

Racial stereotypes may bias assessment.

> *In the case of black clients, we know that the assumptions are based on the many negative stereotyping of blacks as being lazy, lethargic, unmotivated, aggressive, etc. (characteristics which are described in the literature as classic symptoms of depression). As a result of this attitude, blacks who are suffering from depression as a natural outcome of the stresses of living with unemployment, inadequate or unavailable housing, harassment, and racial abuse are not recognized as suffering from stress.*
> *(Submission: Harambee Centres Canada)*

Lacking adequate understanding of a patient's background, a practitioner may fail to understand the significance of certain symptoms. For example, a Canadian doctor may diagnose schizophrenia in a person from a developing country, failing to recognize that the psychotic behaviour results from malnutrition and related Vitamin B deficiency. (Submission: Canadian-African Newcomer Aid Centre of Toronto)

Assessment is a two-way process: while therapists diagnose their patients, the clients are deciding whether their potential therapist is likely to help them. Premature termination of treatment is a major problem. Many ethnic patients do not continue treatment after their first mental care contact and as many as half drop out before five contacts. The most common reason for dropping out of treatment is because of negative feelings towards therapists. Clients often suspect that their therapist is racist. Unfortunately, clients rarely discuss these feelings with the therapist or with anyone else.

Cultural differences also affect clients' responses to and the outcome of the two most commonly used forms of treatment: drug therapy and psychotherapy.

In the view of some ethnic groups, Canadian physicians are too ready to use medication in inappropriate situations. It has been alleged, for example, that Italian Canadian girls have been "treated with neuroleptics (drugs used to suppress psychotic behaviour) when in fact they were going through a traditional mourning process" (Submission: COSTI-IIAS). Research suggests that both Asian and Hispanic patients respond to both neuroleptic and antidepressant medications at lower doses than non-Hispanic whites. In addition, they develop disturbing side effects at lower levels of the drugs. Clinicians who are not aware of such findings and prescribe medication according to dosage schedules, which they have learned are effective with majority culture Caucasians, risk inducing side effects and setting in motion disaffection and premature termination.

While there are many specialized forms of psychotherapy, they are united by the common feature that a patient and therapist come together to explore the patient's problems through talk. The work of psychotherapy may be impeded by clashes in values, differences in expressive and problem-solving styles and incongruence of expectations. Western psychotherapists expect patients to express themselves freely, to disclose intimate thoughts and feelings and to understand that examining emotional conflicts in depth helps resolve psychological problems. However, some Asian cultures prohibit public expression of feelings through words, often relying on subtleties of vocal inflection and gesture as well as a reliance on metaphor whose significance may escape someone unfamiliar with the culture. Many Asians believe that mental disorder is caused by morbid thinking as well as by organic factors. If the practice of psychotherapy forces them to focus on painful (morbid) thoughts and de-emphasizes somatic interventions, many Asian Canadian clients may find psychotherapy inconsistent with their beliefs.

While North American therapists tend to treat their clients in an egalitarian manner, Asians expect a therapist to be an authority who will provide them with direct advice and information. Canadian therapists, as members of a culture which values independence, tend to make emancipation from the family in which they grew up one of the goals of successful therapy. This goal, however, may clash with the values of an Asian or African patient, whose culture stresses that the individual is important only as a member of his or her family.

Whereas many Canadians accept individual treatment as a matter of course, this may be unacceptable in cultures where families continue to play a central role in the lives of individuals.

> *There is a need to talk, to become "related" before the sharing, the unburdening occurs. The counsellor has to become "family." There is a need to drop in and have a place where there is time. Appointments, scheduled interviews, self-disclosure are learned behaviours. Also the way counselling is conducted with Latin Americans is different, it is more often than not a group effort.*
> *(Submission: Hispanic Council of Metropolitan Toronto)*

> *As the family forms the primary relationship for many immigrants and refugees coming to Canada, programmes should, wherever feasible, include family members. The definition of family should in all cases be culturally relevant.*
> *(Submission: Catholic Immigration Bureau, Archdiocese of Toronto)*

The final phase of mental health care — rehabilitation and reintegration into society — poses a particularly difficult problem for both practitioners and patients. With what society is an immigrant to be reintegrated? As the Hong Fook Mental Health Association points out, "If our chronic clients are placed in a day program of a mainstream agency, they will become anxious and disoriented as a result of language and cultural barriers." On the other hand, the ethno-cultural community from which the individual comes is highly unlikely to have any out-patient programs or group homes. In all of Toronto, there are only six ethno-specific mental health services with an average of two full-time staff at each, even though over half the city's population reported non-British ethnic origins in 1981 (Submission: Community Resources Consultants of Toronto). In regions with few immigrants, reintegration in a familiar cultural environment may prove impossible.

The efficacy of mental health services depends on good communication, accurate diagnosis, effective treatment and appropriate follow-up (Lawson et al., 1982). Communication with family, when family are available, is always essential. While Canadian mental health professionals are becoming increasingly skillful at involving families in therapy, the idea of communicating with a community in which an individual may be ultimately imbedded, is a foreign one. The admonition to do so may create difficult professional and ethical issues.

> *We have an individual who sometimes used to talk unrealistic things, but he had been communicating and socializing with some people in the community. After the treatment, he is now in a worse situation because there was something wrong with the approach and procedure of the treatment and the kind of treatment itself. It is true, people are reluctant to reveal their problems, but they have their own connections and network within the community. The Community and individuals in the Community have to be consulted for information before any medical institution or practitioner rushes to treat potential mentally ill people.*
> *(Submission: Eritrean Community in Winnipeg, Inc.)*

This submission illustrates the centrality of community in the lives of some ethnic groups in Canada. The Eritrean community presented its brief with a sense of outrage that one of its members had been admitted to a hospital without prior consultation with the community. In this spirit, the community believed that failed treatment was to blame for the patient's worsened condition. It is possible, however, that the man's behaviour after discharge was part of the process of his illness rather than the result of bad treatment. No one communicated this possibility to the community. If they had, it is questionable whether the Eritreans would be willing to accept this idea.

This case illustrates another problem — the conflict in values between Canadian and Eritrean society. During the hearings, the Task Force indicated that, under Canadian guidelines, if the patient had requested that the community not be informed of his hospitalization, treatment staff, following right-to-privacy guidelines, would have complied with his request. The Eritrean response was that the right of the community to know overrides the right of the individual.

There is no clear-cut solution to this quandary. However, the incident illustrates how alienation and disaffection with the mental health care system can occur if we fail to address the needs of the social network as well as those of the individual patient.

Effective Service Delivery

Concerns regarding the efficacy of mental health services by immigrants and the failure of mental health services to help immigrants are being addressed by individuals, groups and institutions across the country. To a large extent, the impetus for change is coming from the "grass roots" level — front-line service providers and ethnocultural community leaders who see the barriers to utilization and effectiveness at close range.

Since most policies governing the mandate, organizational structure, and funding of mental health services are determined at the provincial government level, service providers and community leaders are limited in the changes they can directly implement. Considerable effort, therefore, goes into advocacy.

Some of the innovative policies and programs reported to the Task Force are the results of such advocacy work. Others exemplify steps that can be taken within existing financial and organizational limits to improve mental health care for immigrants.

A. Interpreters

Language is the most ubiquitous barrier to effective mental health service. At present, untrained, underpaid and unofficial translators are used on an ad hoc basis in situations ranging from psychiatric emergencies to extended counselling sessions.

> *We must first address the lack of professional house interpreters in major hospitals and social agencies, with the exception of Doctor's Hospital and Sick Children's Hospital. Other organizations rely on volunteers, family, or their own unqualified kitchen/cleaning staff. Many patients will not disclose pertinent information to avoid embarrassment and translation may be poorly done because of lack of professional expertise.*
> *(Submission: Portuguese Interagency Network)*

Interpreters are difficult to find. Poor-quality interpretation distresses clients and causes problems in treatment.

> *Using an interpreter in assessment and counselling sessions takes twice as long, and important nuances are frequently missed. Because most social, health and community agencies have suffered staff cutbacks in recent years, and remaining staff are heavily overburdened, the extra time it takes to work through an interpreter is a serious consideration.*
> *(Submission: British Columbia Association of Social Workers)*

Hiring ethnic mental health professionals to work in service agencies seems a way to overcome linguistic and cultural barriers. For several reasons, some of which are discussed in Chapter Eight, this solution is beset with problems. Since it is impossible to imagine that any mental health facility could ever have at least one worker for every ethnic group it serves, mental health facilities will always have to offer help through interpreters, at least to small linguistic communities.

Effort must be directed towards improving translation services.

> *It would be excellent to have doctors or psychiatrists from the same cultural background as patients. As this is not realistic, it is necessary to train interpreters, specifically in this field, for each ethnic group. The interpreters should have an adequate awareness and understanding of the mental health situation in their communities. The most important qualification for interpreters is a deep understanding of their cultural background, the migration and adaptation process, and an understanding of people.*
> *(Submission: S.E.A.R.C.O.M.)*

Funding is the main obstacle to training and using qualified interpreters.

B. Cultural Awareness

Cultures need to be interpreted as well as languages. Mental health service providers often call on staff from immigrant service agencies for language translation and interpretation. After the first contact, others may follow, during which language concerns expand to the acquisition of other information about clients and their backgrounds. As cultural awareness builds in mental health service providers, their services improve.

Reciprocal staff training provides a logical linkage between provincial mental health services and immigrant service agencies (see Chapter Seven).

In the Edmonton Region, the decision was made to develop a Reciprocal Training Program aimed primarily at assisting Settlement Counsellors to recognize mental illness and Mental Health therapists to understand the culture and adjustment process experienced by the predominant immigrant and refugee groups.
(Submission: Alberta Mental Health Services)

When Alberta's Reciprocal Training Program was evaluated, it was expanded to include an informal system of reciprocal case consultation and co-therapy as well as reciprocal education.

Such arrangements often yield three immediate results: mental health practitioners develop an increased awareness of cultural issues affecting service delivery; immigrant service providers gain an understanding of mental health and illness; and immigrant patients probably receive more effective mental health care than they would otherwise.

The mutual benefits and cost effectiveness of reciprocal training, case consultation and co-therapy are lauded by all concerned. Despite the benefits of learning from immigrant service providers, surprisingly few mental health services offer any systematic opportunity for improving staff sensitivity to cultural issues. Instead, a few individuals with a special interest in migrants become members of interagency committees. These committees share information and promote cultural awareness through workshops, newsletters, and advocacy.

The agencies that employ committee members vary greatly in the support they offer committees and the extent to which they are influenced by them. In some instances, mental health services actually spearhead the development of networks. In other cases, however, staff are not permitted to attend committee meetings during work hours.

Cultural awareness should include a knowledge of healing resources within ethnic communities. However, very little is known about indigenous and folk healers. Isolated case reports suggest that people turn for help with emotional problems to such healers, who may have no "official" credentials, but instead, practise by virtue of community sanction. Some commentators suggest that these practitioners represent an untapped mental health resource while others warn against the possibilities of charlatanism. Information for judging indigenous healers is lacking. There is a need to know how and under what circumstances people turn to indigenous healers. Do they use them as substitutes for, or as an adjunct to the health care system? How widespread are these practices in different ethnic communities and what benefits, if any, do they provide? An inquiry into these important questions will benefit from the background of research emanating from developing countries as well as from native Indian communities in North America.

C. Program Development

Innovations in mental health care programming for immigrants are being introduced in existing mental health facilities, in immigrant service agencies, and through outpatient services in community settings.

Multicultural or ethno-specific programs delivered within existing mental health facilities

The barriers to using mental hospitals, psychiatric wards in general hospitals and mental health clinics are formidable, yet resources are concentrated within these facilities, particularly those which can meet the needs of severely disturbed individuals.

The Greater Vancouver Mental Health Service and Vancouver General Hospital have been working towards the establishment of a multicultural clinic which would have such functions as: a central referral or resource centre to help those multicultural cases which the community care teams find difficult to handle; a second opinion clinic; information/data centre; and a base for teaching and training in culture and mental health for mental health workers and residents in psychiatry and family medicine. We would especially like to support this idea of a multicultural clinic, especially the scheme of training multicultural or ethnic mental health workers who can provide effective services to immigrant communities.
(Submission: Japanese Volunteers' Association)

Mental health care delivered by immigrant-serving agencies

Whether multicultural or ethno-specific, immigrant service agencies have fewer problems with access than designated mental health facilities.

Practitioners must make a special effort, however, to secure collegial and professional support.

> *An immigrant-serving program with counselling and psychotherapeutic consultation was established in April 1985 at the Catholic Immigration Centre. More than 164 people have been seen individually by our intercultural therapist.... Since the creation of the service, we have had an opportunity to meet twice a month to evaluate and monitor our work, share our concerns about individual clients, and let off steam when necessary. We have observed an improvement in our work as a team, a more personal approach while at the same time maintaining better professional standards.*
> *(Submission: Catholic Immigration Centre)*

As O.A.S.I.S. Immigrant Services Centre notes, when a mental health practitioner is stationed at an immigrant service agency, advantages accrue to both counsellor and client:

- the implications of cultural background factors and cultural adjustment processes are weighed and discussed by the mental health practitioner with immigrant service staff;

- accurate information on resources helpful to immigrants (family reunification possibilities, language training programs, employment and life-skills training) is readily available from other staff;

- when non-mental health community institutions are involved (Workers' Compensation Board, the legal system, unemployment insurance), the mental health practitioner has the mandate to introduce them to the client, and the client to them; and

- the roles of various mental health resources such as alcohol treatment programs, family counselling services, and self-help groups are coordinated and overseen by the practitioner.

In other words, mental health service providers located in immigrant service agencies can act as case managers, avoiding much confusion and stress for clients and their families while providing and facilitating services that are tailored to the clients' needs (Submission: O.A.S.I.S.).

Outpatient services delivered in community settings

These services are usually linked to particular ethnocultural groups. Ethno-specific mental health services, as several submissions indicated, combine the advantages of general community mental health facilities with the advantages of immigrant service agencies.

One of the main disadvantages of ethno-specific service is cost. Ethno-specific mental health programs are found only in the largest urban areas, and then only in the largest cultural communities. For less populated regions and smaller ethnic groups, liaison services, where immigrant service agencies serve as the bridge to general community mental health facilities, seem the practical solution to the issues of both underutilization and service inefficacy.

Liaison and bridging mechanisms have proven quite successful in getting immigrants with mental illness into care, in explaining mental health services to patients and their families, and in explaining cultural background and context to mental health practitioners. Reintegrating a person with mental disorder into the community, however, calls for more than liaison services.

> *As a result of the trend towards deinstitutionalization, we are faced with a growing number of requests from referral sources for us to participate in discharge planning and to facilitate the treatment and rehabilitation of the chronically and psychiatrically disabled clients in the community.... A day program is to be set up to offer three components of care: day treatment for the maintenance and rehabilitation of the chronically and psychiatrically impaired; a follow-up and aftercare program for the same group of clients who need a lower level of service; and clinical assessment and counselling to serve the wide spectrum of mental health needs of the unilingual clients.*
> *(Submission: Hong Fook Mental Health Association)*

Ethno-specific programs for the rehabilitation and reintegration of immigrant patients are necessary and warranted on two grounds. Individuals recovering from mental illness can be expected to integrate best in a familiar cultural environment. Depending on an immigrant's level of acculturation, that environment will not be found in group homes or halfway programs serving Canadian-born persons.

Depending on the cultural conceptions of mental disorder in an immigrant's own community, his or her needs for housing, social support and employment will not be met. For the unacculturated individual from a traditional community, ethno-specific services are a requisite for successful follow-up treatment.

Conclusions

Funding problems beset efforts to increase immigrant use of mental health services as well as improve the effectiveness of these programs. The same problems also limit attempts to improve the situation for native-born populations and mental health services. For immigrants, however, the problems are of an entirely different magnitude.

> *In 1986, all the multicultural mental health program proposals were given the lowest priority for funding. Of the 11 recommended programs by the Mental Health Care Committee of the District Health Council, only one to some degree addresses the need of non-English speaking groups.*
> *(Submission: Hong Fook Mental Health Association)*

Lack of funding for multilingual, culturally attuned outreach programs results in crises which otherwise could be prevented. Increased demand for emergency services and acute mental health care is also required. Prolonged human suffering often results from delays in early effective management.

> *We believe that more adequate funding is crucial to assist Mental Health Services to become more culturally appropriate. Awareness must be heightened that prevention and early treatment of mental and emotional problems will ultimately be less costly for all Canadians.*
> *(Submission: British Columbia Association of Social Workers)*

Lack of funding for interpreters and multicultural or ethno-specific services compounds the anguish of immigrants in need of help and may result in a premature end to service. It also produces what is known as the "boomerang effect" — immigrant service agencies refer clients to mental health services, only to have them referred back again. Time, money, and energy are wasted in the process.

> *Increased core funding must be made available to develop new services for ethnic communities not currently adequately served and to allow the existing services to meet the demands for service that are a consequence of on-going immigration and, particularly, new waves of refugees.*
> *(Submission: Multicultural Mental Health Group)*

As the *sine qua non* of remedial mental health services, funding requests become the subject of most lobbying efforts:

> *The Group has focussed, for the time being, its advocacy role on ways of ensuring that the problems of cultural and linguistic barriers to service are addressed at the time when decisions are being made about funding. It has adopted the approach, therefore, of attempting to ensure that the District Health Council and all its bodies have as members those for whom the problems of cultural and linguistic barriers, particularly to mental health care services, is a primary concern. It has also requested that the District Health Council require submissions of all new proposals to address the issue of equal accessibility. By having the problems addressed at that level, it is hoped that all resources will eventually develop strategies to ensure equal accessibility to their services. It is also hoped that those who scrutinize such services will come to accept this issue as a basic principle for all health care resources.*
> *(Submission: Multicultural Mental Health Group)*

It is essential that the formal mental health care system become more responsive to the needs of immigrants and refugees. Of the many ways in which mental health service dollars could be used to increase and improve the formal mental health care provided immigrants and refugees, the Task Force assigns priority to four.

Since immigrants and refugees now resist using mental health services, outreach is a prerequisite to service delivery. The Task Force recommends that **Health and Welfare develop, in collaboration with immigrant service agencies and ethnocultural organizations, multilingual educational materials on the psychological consequences of migration and the resources for mental health care. Health and Welfare should provide these**

materials to provincial ministries of health and immigrant service agencies for dissemination through front-line service providers and ethnic media. There is an urgent need as well for Health and Welfare to review and update its existing health- and mental health-related materials to ensure that they are culturally sensitive and relevant.

Trained cultural and linguistic interpreters are imperative for the delivery of effective mental health services. Interpretation will also aid in crossing the barriers that prevent access to mental health services by immigrants and refugees. The Task Force recommends that **Health and Welfare, in collaboration with provincial ministries of health and immigrant service agencies, develop a curriculum for training interpreters used by mental health services. Immigrant service agencies and provincial ministries of health should be provided with this curriculum for use in classes supported by Health and Welfare.**

Making services more accessible requires more creative initiatives and more flexibility in experimenting with models of service delivery. We will need to provide more opportunities for mental health care workers to go to their potential clients rather than to wait for clients to appear in their offices. The Task Force recommends that **Health and Welfare encourage provincial mental health services to employ mental health practitioners at major immigrant service agencies.** Every effort should be made to place professionals who can communicate with a sizeable proportion of clients in their own language.

After treatment, successful rehabilitation and reintegration into society depend on specific programs to serve the needs of migrants. It is recommended that **Health and Welfare encourage provincial mental health services to give special consideration to the funding of ethno-specific rehabilitation and reintegration facilities.**

Other recommendations, which address the need for new program initiatives and training to ensure that workers are culturally sensitive, are presented in Chapter Seven and in the Conclusion to this report.

Chapter 6:

Mental Health Care Outside the Formal Network

The Issue

Parenting classes, peer counselling groups, and visits by a friendly public health nurse help newcomers resolve problems just as they help native-born Canadians. In addition to their major functions, the agencies which provide these services help people cope with stress and, thereby, often help prevent emotional problems from evolving into psychiatric disorders. Although it is not often recognized, community service agencies, some ethno-specific organizations and primary health care providers make up a de facto system of mental health care, operating outside the formal mental health system.

Agencies and organizations which play or could play a role in mental health care can be divided into two categories depending on the populations they serve. General community service agencies and organizations in theory serve "everybody" but in fact are designed for and by members of the majority group cultures. Immigrant service agencies and ethnic organizations exist to meet various needs of foreign-born persons and members of ethnic minority groups.

As noted in Chapter Five, immigrants and refugees prefer to seek help for emotional problems from service agencies and organizations outside the formal mental health system. However, the help they receive from general community services is limited because of cultural barriers, and the help from immigrant services is limited by restrictions placed on funding and mandate.

> *While mainstream agencies are providing some counselling...these agencies lack the linguistic competence and cultural sensitivity to provide appropriate and effective services. Although immigrant aid organizations are prepared to assist in this area, they are not funded for this purpose and lack the staff resources to meet this need. Immigrants and refugees are therefore not receiving proper mental health care even though they represent a very high risk group.*
> *(Submission: ACCESS Committee of Ottawa-Carleton)*

General Community Services

Newcomers are more likely to use an organization which is physically accessible and an integral part of their community life, in preference to one whose services appear specific to mental health.

> *Neighbourhood, non-threatening settings are more likely to be used by refugees in particular, who hesitate to go for "mental help" because they fear it will hurt their...status.*
> *(Submission: B.C. Association of Social Workers, Multicultural Concerns Committee)*

A side benefit is that, the more immigrants and refugees use general community services, the more they become integrated into the larger society.

Submissions to the Task Force suggested that, among organizations serving the general community, family services, public health departments and neighbourhood houses play particularly important roles in migrant mental health. The role of school boards and other agencies focussing specifically on children is discussed in Chapter Nine.

Family services associations provide counselling to families and individuals. The Family Services Association of Metropolitan Toronto, which serves more than 10,000 families and individuals per year, is involved in the resettlement of refugees as well as ongoing counselling. Caseload problems include parent/child and spousal conflicts which have unique cultural dimensions.

Family tensions often arise when immigrant children adopt the ways of the majority culture faster than their parents. When they begin dressing or acting like their peers, children may violate their parents' cultural norms and their behaviour may seem shameful or disrespectful. When immigrant women adopt the Canadian ideology of sexual equality, this can be stressful for husbands and contribute to marital tension. Family service organizations can accommodate these needs by ensuring that their staff represent the major cultural groups, by offering training in cultural awareness and by providing bridging services with ethno-specific organizations.

Some family services associations offer appropriate mental health programs for immigrants as well as the general community, but access to them is limited by financial constraints. Medical care plans do not cover fees for these mental health services.

> *In the area of mental health counselling, agencies such as FSA (Family Service Association) have an additional problem because being outside the formal mental health system, the cost of our services is not covered by OHIP (Ontario Hospital Insurance Plan). Especially in our work with refugees, most recently those from Latin America, we encounter people with significant mental health problems often as a result of violent experience in the homeland. At present, service to such clients is being funded by a combination of charitable dollars, partial government subsidies and user fees. If we are expected to continue to fulfill this need, funding will have to be found to ensure more adequate service access.*
> *(Submission: Family Service Association of Metropolitan Toronto)*

Several **public health departments** have incorporated the multicultural needs of the community into their health promotion programs. Until recently, when funding cutbacks jeopardized their programs, the Vancouver Health Department was providing prevention services to immigrant and refugee elementary and secondary school pupils. These programs, carried out by psychiatrists, nurses and interpreters, many of whom were immigrants themselves, offered two levels of service. Primary prevention included social support groups for parents and teenagers, cross-cultural sensitization sessions with family physicians and community health nurses, and the provision of health education materials. Secondary prevention included direct and indirect case consultation, crisis intervention, short-term counselling, and interagency coordination and follow-up. The cases involved family violence, academic underachievement, and youth anxieties emanating from being caught between peer pressure and traditional family or religious role expectations. In its submission to the Task Force, the Vancouver Health Department stressed the need for a coordinated effort to solve problems; case management must be shared by a variety of persons such as school counsellors, mental health staff and family physicians. The department also stressed the advantages of coordinated problem-solving.

The City of Toronto Health Department attempts to meet the multicultural needs of Metropolitan Toronto by fostering community development, supporting a multicultural mental health workers' network, and disseminating culturally sensitive health-related materials. The department also addresses barriers to access with an equal opportunity hiring policy, and advocacy with planning and funding bodies.

In cooperation with ethnic organizations, the Board of Health in Edmonton operates special programs for immigrants such as prenatal classes, discussion groups on stress, nutrition and family planning, and summer camps for children.

Community-based **neighbourhood houses** also provide services which support mental health. The Association of Neighbourhood Houses of Greater Vancouver acts as a preventive and supportive resource to immigrants by offering pre-school and after-school care, ethnic nights, citizenship classes and special interest groups. A neighbourhood house may assume the role of broker between immigrants and non-immigrants in the community. Sensitizing the general community to cultural differences helps create an environment of acceptance for immigrants.

Immigrant Service Agencies

The activities of multicultural and ethno-specific immigrant services have important mental health ramifications. Some groups provide individual and family counselling to ethnic minorities. Others support ethnic community development. Some organizations serve as a liaison to general community services. And others serve highly specialized roles, such as employment preparation and skills training.

Multicultural ethno-specific agencies employ bilingual and bicultural workers, many of whom have personal experience as immigrants or refugees. Community outreach and public awareness programs are often used to catalyze community development, to promote advocacy, and to educate the general public. Self-help and community organizations created and run by ethnic communities also play a role in mental health.

One example of a multicultural immigrant service agency is the Catholic Immigration Bureau which provides social services to immigrants and refugees within the Archdiocese of Toronto. By using innovative programming with a knowledge of the culture, this bureau dealt effectively with what seemed like an epidemic of marital problems in the Portuguese community. Success was due to the cooperation of professional staff, religious and other community leaders, and to the sensitivity with which the program built upon existing cultural patterns.

> *Patterns that staff observed in the community were channeled through the religious leaders, who then introduced the problem through shared homilies. As a result, members of the community began seeking individual and marital counselling both with the staff as well as with two couples who had solid marriages and who emerged as community leaders. The simulated extended family network began to blossom and relationships that were previously violent, and appeared to be totally dysfunctional, now in this setting began to pull together again with the new "padrinos" (godparents).*
> *(Submission: Catholic Immigration Bureau)*

In the same culturally sensitive manner, the Catholic Immigration Bureau offers settlement services which are integrated with personal, vocational and family assessment and counselling.

Even if they do not have formal social or counselling services, churches to which immigrants and refugees belonged prior to migration are perceived to be sources of aid and comfort in Canada. This makes them a potentially important source of referral for mental health care.

> *Canadian-African sources see a reluctance on the part of African communities to ask for help in the first place, although many are comfortable in approaching the churches for aid. Therefore, the churches may be a valuable resource in the chain of mental health care delivery.*
> *(Submission: Canadian-African Newcomer Aid Centre of Toronto)*

The Strathcona United Chinese Community Enrichment Services Society (S.U.C.C.E.S.S.) in Vancouver is an example of an ethno-specific agency which provides social services for immigrants. This Chinese community social service agency is one of the largest of its kind in Canada. S.U.C.C.E.S.S. offers family life education, marriage enrichment, and parenting groups. O.A.S.I.S., the Orientation Adjustment Services for Immigrant Societies, also in Vancouver, provides language translation and family counselling as well as formal mental health services. In Toronto, the COSTI-IIAS Family Counselling Centre assists Italian Canadians in resolving spousal and intergenerational conflicts. Newcomers from Africa living in Toronto can obtain help from trained ethnic counsellors at the Canadian-African Newcomer Aid Centre of Toronto (C.A.N.A.C.T.); those from Portugal living in Montreal, from the Centre Portugais de Référence et Promotion Sociale.

The Southeast Asian Services Centre, a multi-services agency in Toronto, operates a public housing project for Vietnamese refugees. Through non-threatening activities such as social clubs for seniors, the centre also attempts to create a familiar environment for migrants. The South East Asian Refugee Community Organization of Manitoba (S.E.A.R.C.O.M.) develops familiar cultural activities for Southeast Asian youth.

> *A community support program is an effort to recreate some aspects of the Southeast Asian culture to provide badly needed support systems. Enjoy cultural activities (such as their best loved sport games); this makes them feel at home. Do homework; this is especially for students with low educational background and unfitted in the Canadian education system to consult with others. Release family and school pressure. Make friends; this is very important for some teenagers and youths who came alone to Canada. Create an opportunity for leadership training. Support and provide information or counselling to each other.*
> *(Submission: S.E.A.R.C.O.M.)*

> *Southeast Asian people believe that a happy family will have productive and healthy children for the society. Based on that, we believe that prevention should be broader, larger and deeper, involving the whole community so that all people in the community become aware of what is going on and will take the responsibility for the whole community as one family.*
> *(Submission: S.E.A.R.C.O.M.)*

The Jamaican Canadian Association, which introduces community support through its "Pal Program," organizes volunteers to act as big brothers or sisters to young people in need of a friend and role model.

Some ethno-specific agencies in larger urban centres have a specific focus on mental health. Community Resources Consultants of Toronto reports five ethno-specific mental health services in Metropolitan Toronto which serve immigrants and refugees. They include: Hong Fook, an organization which offers supportive services in addition to providing inter-agency liaison; Breakthrough, a weekly support group for Italian women; Jerry Turk Fellowship Home, a supportive housing resource with a Jewish orientation; Portuguese Community Mental Health Project, an assessment and counselling service; and Kensington Clinic, an addictions clinic for Portuguese people.

Ethnic communities develop at different rates and have varying needs and specific concerns at different times. Ethno-specific agencies help fulfill immediate needs, particularly for those clients who do not speak one of Canada's two official languages. Ethno-specific agencies may not, however, constitute a viable long-term solution for all groups. Some ethnic groups may not wish to support such services. Exclusive reliance on ethno-specific services also reinforces the marginalization of clients and may isolate ethnic paraprofessionals in dead-end career paths.

Liaison Organizations

Some organizations enhance the mental health of immigrants and refugees indirectly by coordinating the services of other agencies. Instead of providing direct service, these groups are dedicated to forging links between general community services and immigrant or ethnic services.

The Immigrant Access Service of Manitoba, with a multicultural, multilingual staff, provides an important model for long-term planning. The Hong Fook Mental Health Association of Toronto provides another example.

> *Hong Fook does not provide primary care services but rather acts as consultants and cultural brokers through bilingual and bicultural workers*
>
> *i) Consultation to professionals and agencies with regard to culture, case management, program planning and community resources;*
>
> *ii) Assessment or assisting in the assessment of individuals and families in their homes, agencies and institutions;*
>
> *iii) Liaison and referral to link clients with appropriate resources to meet their needs;*
>
> *iv) Short-term supportive counselling to individuals and families to assist them in coping with stressful situations;*
>
> *v) Interpretation, advocacy and escort for individuals and families who have mental health problems;*
>
> *vi) Case management in the community;*
>
> *vii) Education to individuals, families and the community at large about mental health and;*
>
> *viii) Education to health care providers regarding Chinese and Southeast Asian health beliefs and practices.*
>
> *(Submission: Hong Fook Mental Health Association)*

Like some other liaison organizations, Hong Fook serves an ethno-specific clientele. This is an important feature because it recognizes and promotes the importance of cultural values in providing services. "It is important that solutions should be sought within the particular cultural context, that is, the values in terms of which people organize their lives" (Agard, 1987).

Other liaison organizations include the Portuguese Interagency Network, Metropolitan Toronto Multicultural Mental Health Group, Multicultural Health Coalition, and Alberta Association of Immigrant Serving Agencies.

Fragmented Service

The well-being of immigrants and refugees is, or should be, the business of all levels of government and all agencies — the formal mental health care system, general community services and immigrant service agencies. Many of these entities demonstrate the dedication and creativity of Canadians committed to the business of resettlement. At the risk of discouraging these efforts, it must be recognized that they offer a fragmented service. Provincial services are organized in ways which make sense for a stable society but not for newcomers, whose needs tend to be interdependent and overlapping. Language difficulties are inextricably tied to job training and employment; concerns about housing, which merge with needs for social benefits, may have an important impact on health.

Newcomers' needs cannot be neatly divided to conform to the speciality of a particular agency. Staff of government ministries and government-supported agencies tend to become specialized in dealing with a particular type of problem. Immigrants and refugees frequently find themselves on an exhausting and demoralizing trail of referrals from one office to another in search of more specialized help, for reasons which they cannot understand and which they may interpret as rejection.

The inefficiency and frustration which result from fragmentation has led some to call for governments to change the way they are organized to meet changing needs.

> *There should either be one central government department or ministry which looks after the settlement and welfare of immigrants and refugees (including social services, language training, employment and job training, social benefits, health, etc.) or communication between departments should be improved. Otherwise, the well-being of immigrants and refugees could end up being nobody's business.*
> *(Submission: S.U.C.C.E.S.S.)*

The benefits of an integrated system of care, with optimal communication and cooperation between service agencies, are recognized both by communities and by care-giving organizations. One of the submissions to the Task Force painted a realistic picture of how better integration of service would help overcome the barriers to mental health care experienced by so many new settlers.

> *We think there is a place for an informal, outreach type of program if this community is to be best served by the mental health care system. The nature and tradition of African hospitality makes the African home highly accessible, and in this surrounding patients may well be amenable to therapy. Alternatively, the mentally distressed African immigrant might be made aware of mental health care facilities through the churches or trusted ethno-specific agencies, provided good lines of communication and referral are established between the agencies and the mental health practitioners. Some transcultural practitioners are familiar with the cultures of their African patients, having lived in Africa themselves, but most would need advice in African cultural matters. Ethno-specific agencies can often provide this, and practitioners might do well to liaise with these as the need arises.*
> *(Submission: Canadian-African Newcomer Aid Centre of Toronto)*

This excerpt is important in that it indicates that the mental health care system is a link but not necessarily the final link in a chain of care. There is a role for representatives of ethno-specific organizations to act not only as sources of referral for mental health care, but also as consultants and interpreters during treatment, and as helping agents in planning after-care and rehabilitation following an episode of illness.

To some extent, fragmentation results from competitiveness, both personal and at the level of agencies and bureaucracies. Instead of cooperating, agencies find themselves competing for scarce resources, whether for personnel with special attributes and skills or for funding. The Task Force believes, however, that the source for many of the difficulties is structural; the way in which services are organized is dictated too much by political and professional fiefdoms rather than by patterns of need.

Remedies for this situation must include incentives for service agencies to become more responsive to the needs of immigrants and refugees. The Task Force recommends that **Health and Welfare and Secretary of State encourage all funders of social and health services to require that organizations applying for funds provide evidence of efforts to make their services accessible to ethnic minorities and to provide evaluations of their effectiveness**. Funding criteria should include linkages between general community services, immigrant service agencies and ethnic organizations, and interagency committees to develop, monitor, and refine means of liaison.

Mental health must become a recognized part of the mission of agencies which deal with immigrants and refugees. Health and Welfare should encourage and support the immigrant volunteer training programs with peer counselling components at immigrant service agencies. Incentives must be provided to stimulate mental health services to integrate their expertise with community, immigrant serving, and ethno-specific agencies. The Task Force recommends that **Health and Welfare identify immigrants and refugees as well as multicultural concerns among its priority areas for Health Promotion contributions, research and National Welfare grants, and other funded activities**. Health Promotion Contributions should be available to promising and deserving organizations whether they are nationally or provincially based.

To reduce fragmentation of services and enhance integration, a new group should coordinate and monitor programs as well as enhance cooperation between the many agencies and departments serving immigrants in Canada. The Task Force recommends that **Health and Welfare establish a national advisory body to coordinate and monitor social, health and mental health services to ethnic minorities, with participation from professional associations, service administration, and immigrant service agencies**. Health and Welfare should also encourage the creation of a similar advisory body in each province.

When appointing persons to federal or provincial advisory councils, boards, and commissions on health, mental health and social services, Health and Welfare and its provincial counterparts should consider the candidate's knowledge, experience, and sensitivity regarding immigrant and ethnic minority issues.

Chapter 7:

Training for Service Providers

The Issue

While most clinicians probably would agree that it is important to understand a client's culture, the challenge remains to translate this proposition into training programs for mental health personnel. Appropriate training can help practitioners understand more specifically how culture affects the definition and presentation of mental disorder, how it shapes the therapist-client interaction, and how it helps determine response to treatment.

Several undergraduate, post-graduate, and in-service programs across Canada provide cross-cultural training to students and practitioners in mental health fields. However, this training does not assume a high priority. It is rarely mandatory or evaluated. Reports of apparently successful training programs have not been widely circulated so that they can be copied in or adapted to other settings.

To ensure that mental health care providers receive the training they need to work with a multicultural clientele and to serve on advisory bodies, the federal and provincial governments must provide incentives to educational institutions and professional associations to make cross-cultural training a priority.

Classroom Curricula

While many Canadian colleges and universities offer courses focussing on consciousness-raising and cultural sensitization, there are no requirements that future service providers participate in this curriculum. In addition, Canadian professional organizations and accreditation bodies have assumed little initiative in designating cross-cultural training as a priority. The result is that immigrants and refugees experience limited access to culturally sensitive service providers.

Initiatives in cross-cultural training are usually undertaken by interested individuals who may not always have ongoing administrative support. The

Department of Counselling Psychology at the University of British Columbia and the Clarke Institute of Psychiatry in Toronto are two examples of such programs in Canada. Submissions indicated the need for cross-cultural training for specialists in a wide range of services: educators, family therapists, general practitioners, nurses, psychiatrists, psychologists, public health personnel, and social workers.

Submissions to the Task Force suggested that course content must be designed to teach students how sociocultural factors affect the occurrence, presentation and prognosis of illness as well as how people go about seeking care. Specific topics should include:

- pre- and post-migration factors which increase risk;
- the impact of socio-political and cultural factors on diagnosis;
- how culture affects perceptions of the cause of illness;
- socio-cultural factors affecting the development, onset and cause of illness;
- the effects of culture on help-seeking patterns, treatment and response to care;
- service needs of "high-risk" groups such as torture victims, the elderly, children, adolescents, and women; and
- differentiating between immigrants and refugees and their respective problems and needs.

Knowledge of specific cultures may not necessarily be transferrable. Awareness of Japanese culture may help a family practitioner in Vancouver, where a significant Japanese population resides; but if the practitioner were to move to Montreal, familiarity with Portuguese or Algerian culture would probably be more relevant. Programs for most professionals should include a generic cultural sensitivity component complemented by more specific education about local cultural groups.

Field Training

As far as the Task Force was able to ascertain, none of the accreditation bodies that control training requirements for professional groups such as family medicine, nursing, psychiatry, psychology and social work requires training in cultural sensitivity. The Royal College of Physicians and Surgeons of Canada requirements for specialization in psychiatry include knowledge about "psychosocial reactions to disease." However, training guidelines do not specify a component in cultural awareness. Similarly, the College of Family Physicians of Canada does not list training in cultural sensitivity among its requirements.

The accreditation criteria for clinical psychology programs and internships of the Canadian Psychological Association (1984) specify an ideal that, if acted upon conscientiously, would help ensure effective psychological services for minority group clients. The criteria state: "respect for cultural and individual differences are attitudes which should be reflected in all phases of a programme's operation, including faculty recruitment and promotion, student recruitment and evaluation, curriculum planning, and field training." The statement stops short, however, of requiring mandatory cross-cultural training.

Professional accreditation bodies do permit individual initiatives in training programs across the country. The resident training program at the Department of Psychiatry, McGill University, devotes 10 hours of seminar time to culture-related topics such as culture and depression, schizophrenia and culture, culture-bound syndromes, and cultural influences on substance abuse. A comprehensive survey of the amount of cultural sensitivity education in Canadian psychiatry training programs is not available. However, a 1977 survey conducted in the United States inquiring about the teaching of cultural issues in psychiatric residency programs is instructive. Of 110 training programs which responded to the questionnaire (a 50 per cent response rate), 10 per cent stated that they offered a special course on minority/transcultural issues and 35 per cent said they included these issues in connection with other topics (Moffic et al., 1987). A 1984 study suggested that, in the seven-year interval, interest in cultural teaching in U.S. programs declined.

Social work education in the U.S. may emphasize cultural issues more than other disciplines, but comprehensive survey results are not available. The lack of training in cultural matters in psychology appears to be quite similar to that of psychiatry. In the 1970's, conferences and guidelines recommended an increase in this education in American psychology programs; however, a survey in the 1980's found that well below half of the responding graduate programs offered cultural psychology courses (Moffic et al., 1987).

Cultural training in Canada in psychiatry, psychology, and social work is probably not too different from that in the United States, but surveys of training programs in Canada would now seem to be warranted. Service delivery is very different from that of the U.S. The availability, content and methodology of training are influenced by demographic distribution of immigrants and refugees; cultural background of the client groups most frequently encountered in practice; and government policy regarding the provision of services.

In-Service Education

Submissions to the Task Force strongly reinforced the need for cross-cultural training of persons already engaged in the delivery of social, health, educational and legal services. There is a need to be aware of the similarities and differences. Policies, programs and resources are required to improve staff competence in assessment, diagnosis, treatment and rehabilitation. Training programs should also target the needs of "high-risk" groups such as torture victims, women, adolescents, children and the elderly.

In Canada, training in health and social service agencies, most of which occurs on an ad hoc basis, is usually developed by agencies to meet their immediate needs or at the initiative of agency staff with a special interest in the topic. Since most of these training activities are propelled by the press of cases seen at the agencies, they do not evolve into ongoing, requisite or long-term educational programs.

The large numbers of immigrants and refugees settling in urban areas force agencies to provide their staff with training. In this situation, professionals and/or leaders from the immigrant and refugee communities can assist with training. Social and health service agencies and other general community organizations across Canada are employing an increasing number of persons with minority-group backgrounds. These workers also require training in order to deal with persons from cultures other than their own.

In smaller centres located far from resources, the lack of pressure often leads to a diminished sense of priority for cross-cultural training. When immigrants and refugees with problems are encountered, lack of training leads to helplessness and frustration on the part of immigrants and staff. As the Association for New Canadians in St. John's, Newfoundland stated, "The most frustrating thing for those of us who are trying to help is a sense of powerlessness and a lack of knowledge about where to turn for help."

Models of training exist which can be adapted to cross-cultural education of service providers in less populated areas. For example, a multidisciplinary team which travels regularly to health stations in the Arctic provides consultation, clinical supervision and in-service training to Inuit health workers. The Itinerant Worker Model in Settlement Agencies, Alberta Mental Health Services, assists many practitioners outside Edmonton. Technology such as interactive television, audio-visual aids and self-instruction packages can also be harnessed for these purposes.

Role of Immigrant Service Agencies

A recent report entitled *Access to Health and Social Services for Members of Diverse Cultural and Racial Groups* by the Social Planning Council, Metropolitan Toronto, states:

> *As the study proceeded, it became apparent that the health and social service "systems," at least for members of diverse cultural and racial groups, could be characterized as a situation of two solitudes...existing side by side but separate, not taking account and not accounting to one another.*

This aptly describes what appears to be happening throughout Canada. Lack of funding is often cited as an obstacle to providing cross-cultural training for mental health practitioners and mental health training for ethno-specific, front-line workers. Yet very few models have been tried that provide much-needed training for both groups.

Several submissions outlined how immigrant service agencies are involved in the cross-cultural training of staff in general community services, not only to increase their cultural awareness and sensitivity but also to raise their level of comfort and effectiveness with immigrants and refugees. Many of these immigrant service agencies conduct conferences and seminars, and consult with staff of general community services. Some also provide field placements for students. The efforts of the Hong Fook Mental Health Association present a model of how multicultural and ethno-specific agencies can and do provide training for general community service workers.

> *Hong Fook Mental Health Association organizes educational activities to sensitize mental health care providers to the need of our target population and provide information on culturally relevant approaches to working with our clientele. Examples of these activities are the annual professional conference and lunch seminars. The Hong Fook staff also make presentations to agencies and groups. We have been approached by faculties and students of professional training schools to provide field placements.... We have reallocated some funds from the 1986-1987 budget to contract a researcher to conduct a study on how to develop a program to train health and social service providers for Southeast Asian communities. (Submission: Hong Fook Mental Health Association)*

Although they have neither the mandate nor the educational or occupational backgrounds to provide mental health services, minority group staff workers in multicultural and ethno-specific agencies are often forced to deal with clients who have psychological problems. To make their work more effective, these workers need to be exposed to basic mental health concepts, to understand how to recognize problems early and to be equipped to make appropriate referrals.

The Reciprocal Training Program in Alberta has designed a program to address these needs. The Clarke Institute of Psychiatry in Toronto also provides a training program for immigrant settlement workers called "Understanding Psychosocial Problems and Psychiatric Disorders in Immigrants and Refugees." These seminars cover the symptoms, treatment, and management of major psychiatric diagnoses such as schizophrenia, manic-depressive psychosis, somatoform disorders, and anxiety disorders, plus discussion of cultural matters such as the impact of culture on the pattern and management of psychiatric disorders.

The reciprocal training arrangement is ideal from a financial perspective. Other alternatives include lending training staff to different agencies and purchasing service agreements between general community and immigrant service agencies.

Regardless of which model is used, the goals of training should include:

- sharing much-needed cross-cultural insights;
- sharing limited training resources;
- networking;
- utilizing the strengths in each other; and
- breaking down suspicion and lack of trust.

Whether training is geared to service providers from the majority culture or to minority group workers, it is important to actively seek the involvement of immigrants and refugees. Their knowledge and experience can enrich the content of any program. Several presentations to the Task Force warned against the danger of stereotyping other cultures. Suggested ways to involve immigrants in the planning, implementation and evaluation of training programs include: consultation with a multicultural advisory committee; involving members of ethno-specific communities as guest speakers or lecturers; having segments of the training take place in situ, as Alberta's Reciprocal Training Program operates.

This approach:

- ensures that training is culturally sensitive and appropriate;
- utilizes the resources and talents of immigrants and refugees and invites them to participate in society;
- encourages the emergence of leaders in the immigrant community; and
- enhances the much-needed linking of the "two solitudes."

Innovative Training Method

"Culture brokers" are persons who can help bridge the gap between the culture of a client and the culture of professional care-givers. Culture brokers can translate a bewildering world of professional attitudes, strange jargon and endless referrals to clients. At the same time, they help professionals understand how the culture of a client has helped shape his or her problems.

Culture brokers have evolved out of necessity in a variety of places. The Province of Manitoba has initiated an innovative program to train culture brokers. Students selected from the largest ethnic groups in the province have been enrolled in a program which will provide training in health and social service delivery as well as cross-cultural sensitivity. This potentially important program should be carefully monitored and its results made widely available.

Conclusions

Canada's multiculturalism policy has had limited effect on professional, educational and service delivery institutions. Because there appears to be a lack of direction from ministries, professional organizations and department heads, cultural training is often offered only as an elective or on an ad hoc basis. It is not surprising, therefore, that with few exceptions, cultural education in Canada is essentially "preaching to the converted."

Funding is definitely lacking, as is an explicit mandate to procure funds for cross-cultural education. Training in cultural sensitivity must become an on-going priority of educational institutions, and of both general community and immigrant service agencies. Teaching materials, other than printed information — for example, audio-visual materials — should be developed and made available to groups across the country. A list of individuals who can make significant contributions to the planning, implemention and evaluation of educational programs should be compiled and made accessible to interested groups. An evaluation process must be built into any program to measure effectiveness. A range of flexible programs to accommodate the educational needs of various disciplines in different regions of the country must be developed.

To achieve these objectives at minimal cost, existing resources must be used in developing training modules and in the delivery of cross-cultural training programs. The Task Force recommends that **Health and Welfare invite requests for proposals on the development of cross-cultural training modules in education, family practice, nursing, psychiatry, psychology and social work.** The programs developed for each discipline should be made available by Health and Welfare to each educational institution and professional association responsible for the training of professionals in that discipline.

The delivery of cross-cultural training requires more than training materials and recognition of their importance. The "political will" to implement them is needed. The Task Force recommends that **Health and Welfare, Secretary of State and their provincial counterparts encourage institutions of higher learning to identify cross-cultural education as a priority, particularly for students of education, medicine, nursing, psychiatry, psychology and social work.**

The training modules developed for each discipline and disseminated to each training program may also be adapted for in-service use by general community agencies. This type of education is still more effective, however, when delivered by staff of immigrant service agencies.

Since immigrant service workers who will provide cross-cultural sensitivity require training themselves, reciprocal inter-agency training agreements should be encouraged and expanded wherever possible.

The Task Force recognizes, however, that there are many more general community services agencies and staff than immigrant service agencies or staff. The demands on immigrant service staff for cross-cultural training in many cases already impinge on the time needed for direct services to clients. The development of effective cross-cultural training modules should make training more efficient, and help limit demands on immigrant service agencies to reciprocal, mutually beneficial arrangements.

Chapter 8:

Ethnic Practitioners

The Issue

When practitioners are fluent in the language and culture of immigrant and ethno-cultural groups, patients tend to use services more readily, disclose information more fully, and follow through with treatment more faithfully than when an interpreter is required. However, minority group practitioners are in desperately short supply. Ironically, professionals trained in other countries who might serve ethnic clients are often barred from practice by licensing restrictions and by the admissions requirements of post-graduate institutions.

By liberalizing the evaluation of foreign-earned mental health credentials, and by actively recruiting minority group applicants to enter mental health training programs, Canada could capitalize on professional expertise already available. This would be a significant contribution to the mental health care of migrants.

Nature and Scope of the Problem

Virtually all the submissions to the Task Force expressed a need for more mental health practitioners who speak the language and know the culture of immigrant clientele.

> *The clearest need is for mental health professionals from the ethnic communities, who are interested in their own language and culture and who can integrate North American practices with those of their own culture.*
> *(Submission: Intercultural Association of Greater Victoria)*

Practitioners feel more satisfied when they can communicate directly with clients and are more confident in their diagnoses when they are familiar with the cultural context of symptoms. In addition, minority group practitioners serve as role models for their immigrant patients; they provide effective outreach to immigrant communities, and they represent a valuable source of consultation and in-service training for majority group colleagues.

As noted in Chapter Five, working through interpreters during counselling and therapy is a second-best solution to the need for linguistically and culturally appropriate mental health care.

> *It is not effective to have people who speak the language and who can translate and interpret only. This target population requires professionals who have cross-cultural training, language facility and the skills to deal with this population's socio-emotional problems (social worker, clinical psychologist and medical personnel). Ideally, a mental health professional of their own background is preferable for obvious reasons. (Submission: Toronto Board of Education)*

Several submissions described a "boomerang effect," whereby minority group settlement workers and general practitioners refer immigrants to psychiatrists and psychologists who do not learn the culture, only to have them referred back again.

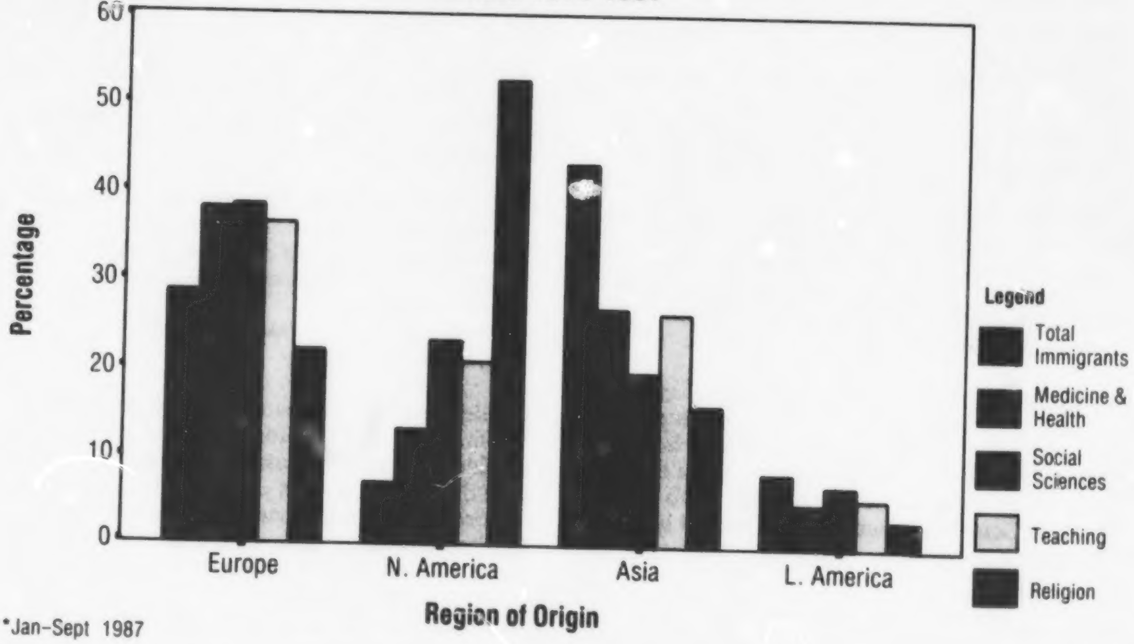
Figure 8.1 examines the proportions of professionals in health and allied fields from Europe, North America, Asia and Latin America admitted to Canada relative to proportions of all immigrants from the same areas. Europe accounted for about 28 per cent of all immigrants from 1978 to 1987, but almost 40 per cent of health, social science and education professionals. By contrast, newcomers from Asia made up 45 per cent of all immigrants, but only about 25 per cent of health professionals, 20 per cent of the social science professionals and 28 per cent of the teachers. The over-representation of professional groups is even more marked in the case of migrants from North America than from Europe.

We do not know how, where and whether these people practise their professions. Nevertheless, from the data in Figure 8.1, one can reasonably infer that European immigrants and North American-born persons with mental health needs have available to them more professionals from their own ethnic backgrounds than non-European migrants. Even if all professionals admitted were allowed to practise, Asian clientele would likely be under-served relative to European and North American-born migrants. However, restrictive policies and licensing restrictions, which make it particularly difficult for Asians and Latin Americans to practice their professions, compound the problem.

Figure 8.1

Distribution of Total Immigrants and Distribution of Immigrants in Selected Helping Professions by Region of Origin

Canada 1978-1987*



*Jan–Sept 1987

Immigration Selection Policies

At the federal level, Employment and Immigration Canada strives to select, for its Independent Class of immigrants, persons whose training and experience can be used in the Canadian labour market. "Employment-related factors account for about half of the total possible rating points that can be awarded" under the present point system (Employment and Immigration Canada, 1986). Individuals with pre-arranged employment or with good prospects of self-employment receive extra rating points.

Medical doctors are actively discouraged from applying to immigrate (Canada Employment and Immigration, March 27, 1987). The few physicians who immigrate in the Independent Class are selected abroad to fill specific, pre-arranged positions. Physicians may also enter Canada in the Convention Refugee and Family Classes, but they do so with the knowledge that they may never be able to practise their profession.

Other mental health practitioners, such as psychologists, social workers and psychiatric nurses, do not receive official "negative counselling" from Immigration. But they also do not immigrate in large numbers. A recent agreement signed between the Canada Employment and Immigration Commission (CEIC) and the Canadian Public Health Association (CPHA) may help remedy this situation. CEIC and CPHA will work together to guarantee that members of at least visible minority groups have "full representations at all levels in the public health field" (Canada Employment and Immigration, February 24, 1987).

Licensing Requirements

By controlling registration and licensing, professional regulatory bodies attempt to ensure that all practitioners meet Canadian standards of proficiency. It is assumed that these standards are best met through Canadian education and Canadian training. Recognition of foreign degrees and experience varies widely between professions and between provinces. On the whole, it is difficult to obtain.

Immigrants who must repeat or who wish to repeat their training prior to taking professional qualifying examinations may be excluded from educational institutions by admissions criteria, including language requirements. Physicians face a further dilemma. Even if they meet admissions criteria, the number of intern and residency training positions available barely exceeds the number of Canadian medical school graduates, who are given first priority for training positions (Canada Employment and Immigration, March 27, 1987).

In addition to being extremely difficult and time-consuming, obtaining permission to practise as a mental health professional in Canada can be costly. Fees must be paid to have foreign qualifications estimated for equivalency, to take oral and written examinations, and to become registered or licensed. If re-training is necessary, immigrants or refugees must support themselves and any dependents as well as pay their tuition.

Hiring Policies

Migrant mental health professionals who manage to become certified usually find themselves competing with Canadian-born applicants for suitable positions. In the past, official hiring policies have not given preference to individuals who might best serve under-served ethnic minorities. There are, however, signs of change. In some major urban centres, a limited number of specialized postions have been created for, and filled by, ethnic minority persons. Even for routine positions, the Vancouver Health Department advises that "ability to speak a second language and knowledge of different cultures" are assets. The City of Toronto has adopted an Equal Opportunity policy which, along with equal access for citizens, aims to ensure that "employment practices and policies are equal for all employees and applicants" (Submission: Toronto Department of Public Health).

Except for persons in specialized positions, ethnic mental health practitioners hired by general community agencies tend to serve all clients regardless of ethnic background. Clients who speak only the language of the ethnic practitioner may be transferred to that practitioner, but such transfers rarely take place for cultural reasons alone. Many government sector agencies have geographical boundaries which practitioners may not cross even if their skills are greatly needed in another jurisdiction. In these cases, in addition to carrying their own caseloads, practitioners often provide extensive consultation across boundaries.

The bicultural professionals already in the field face a particular dilemma. Some try hard to be "a-cultural" to avoid being penalised for their ethnicity. Others attempt to serve patients of their own group only to be overwhelmed with the need without backup by the agency.
(Submission: Lo)

Immigrant service agencies are places where immigrant mental health professionals could be logically employed. Nevertheless, two of the main funding sources for these agencies, the Immigrant Settlement and Adaptation Program (ISAP) and Secretary of State — Multiculturalism, do not permit settlement workers funded under their programs to carry out counselling and therapy (Chapter Five). The funding provided is stretched to the point where too few workers have too many clients. Immigrant-serving agencies "cannot possibly offer salaries or working conditions attractive enough to recruit many of the well-educated, widely experienced professionals in the ethnic community."
(Submission: Herberg and Herberg)

Very few immigrant psychiatrists and psychologists set themselves up in private practice. Psychiatrists who are willing to see patients of their own cultural background are usually overwhelmed by severely disturbed cases. The deep and pervasive stigma against mental illness prevents individuals from seeking help until crises occur. Psychologists may be less affected by the intense stigma regarding emotional or behavioural problems, but because their services are rarely covered by medical insurance plans, they seldom see even critical cases. Migrants with minor mental disorders turn to general practitioners, where, for reasons discussed in Chapter Five, the psychological nature of their problems may or may not be discerned.

Conclusions

The availability of ethnic mental health practitioners is severely limited by the licensing and registration policies of professional regulatory bodies, combined with the admissions requirements of post-graduate institutions. These policies also have significant implications for the mental health of the professionals themselves who, despite their years of learning and experience, face the prospect of unemployment or underemployment (Chapter Four).

Health and Welfare and CEIC should explore with professional regulatory bodies ways and means of enabling immigrant mental health professionals to work, under appropriate supervision, in settings where they could provide mental health care to immigrant clients (Chapters Five and Six).

In making this suggestion, the Task Force recognizes the balance between the need to expand the pool of ethnic mental health professionals and the equally important need to ensure standards of practice.

Health and Welfare and CEIC should also explore ways to recruit persons from ethnic communities to enter the mental health professions.

The Task Force recommends that **Health and Welfare and Secretary of State encourage the admissions committees of social, health and mental health service training programs to recognize as assets fluency in a non-official language and intention to work with clients who speak that language.** Social, health and mental health training institutions should also be encouraged and supported by Health and Welfare, Secretary of State, and CEIC to offer scholarships and fellowships which stipulate fluency in a non-official language, and intention to work with clients who speak that language. Minority group professionals should be actively sought for nomination to the boards and committees of professional regulatory bodies; training institutions should be encouraged to liberalize licensing requirements and promote ethnic participation in mental health training programs.

Broader criteria for licensure and increased opportunities for training and work experience will effectively increase the numbers of ethnic mental health professionals eligible to work in the community.

General community service agencies must recognize the serious need for minority group service providers and revise their hiring policies accordingly. The Task Force recommends that **Health and Welfare and its provincial counterparts encourage all social, health and mental health service agencies to increase their hiring of ethnic minority staff through the adoption of equal employment opportunity policies.** The client intake policies of general community service agencies should also be revised so as to make ethnic minority staff available to minority group clients regardless of agency boundaries.

Part IV:

Special Needs

Chapter 9: Children and Youth 65
Chapter 10: Women 73
Chapter 11: Seniors 79
Chapter 12: Victims of Catastrophic Stress 85

There are two major reasons for devoting a section of this report to the special mental health needs of children and youth, women, seniors and victims of catastrophic stress.

The first is that, because of their experiences prior to migration or their particular situation during resettlement, or a combination of the two, these groups suffer a particularly high risk of developing mental health difficulties. The psychological wounds of persecution, torture and rape heal slowly and with great difficulty — if ever. The brutalizing effects of being exposed to war and persecution take a toll on the developing personalities of children and youth. Dislocations and interrupted schooling may make it difficult for them to integrate. Canadian immigration and resettlement policies also create risk-inducing stress for women and the elderly.

Besides elevated risk, the second factor common to these seemingly disparate groups is that they are usually socially disenfranchised. They lack a powerful voice — social and/or political — both within their particular ethnic communities and in the larger society. The lack of voice arises from different sources. For children, women and the elderly, it is the product of social structures which render them relatively powerless. Victims of such catastrophic stress as rape and torture are reluctant to talk about their needs because of fear of danger or stigma.

Special needs groups are "special" because they are in double jeopardy — their risk for developing disorder is high and the chances of their needs being addressed is low.

Special needs groups are "special" because they are in double jeopardy — their risk for developing disorder is high and the chances of their needs being addressed is low.

Chapter 9:

Children and Youth

The Issue

While people make and remake themselves throughout life, it is a particularly central task for children and adolescents. Out of their struggles to remain loyal to family but to become emancipated at the same time, to understand how to be intimate and loving with others, to recognize and capitalize upon abilities while accepting limitations, emerge the traits which we call adaptive behaviours. Patterns of adaptation laid down in childhood and adolescence are important precursors for mental health later in life.

While it is reasonable to assume that migrant children and youth face unique problems and therefore experience an elevated mental health risk, there has been no research to date to confirm or refute this proposition. All children struggle to build a sense of coherence out of the family in which they are raised and the larger society in which they participate. Children of migrants confront additional issues. Unlike many of their playmates, their mother tongue is not English or French and their family may be very different from that of their friends. Some migrant children experienced prolonged separation from their parents, sometimes being left in the home country while their mothers and fathers struggled to earn enough money to bring their children to Canada. Reunification, which usually means a second separation, this time from parent surrogates and the only homes they have known, creates psychological distress.

Many immigrant (and especially refugee) youth have experienced disruption in their education to the point where, after entering Canada, they are too old to enter the regular school system yet unqualified to enter the work force as anything but unskilled labour. These youth are often trying to relinquish the culture of their parents, a culture which they see many Canadians devaluing and which seems to them to constitute a barrier to full acceptance by the majority society. Their rejection by the labour market, which creates a feeling of double alienation, may result in emotional distress. A few youth gangs drawn from migrant groups have threatened communities and tantalized the news media. Evidence suggests that adult criminal elements may be recruiting members for these gangs from the ranks of marginal young persons who no longer feel at home with their families and their own cultures, and who become disaffected by failed attempts to enter the consumer-rich society they see around them.

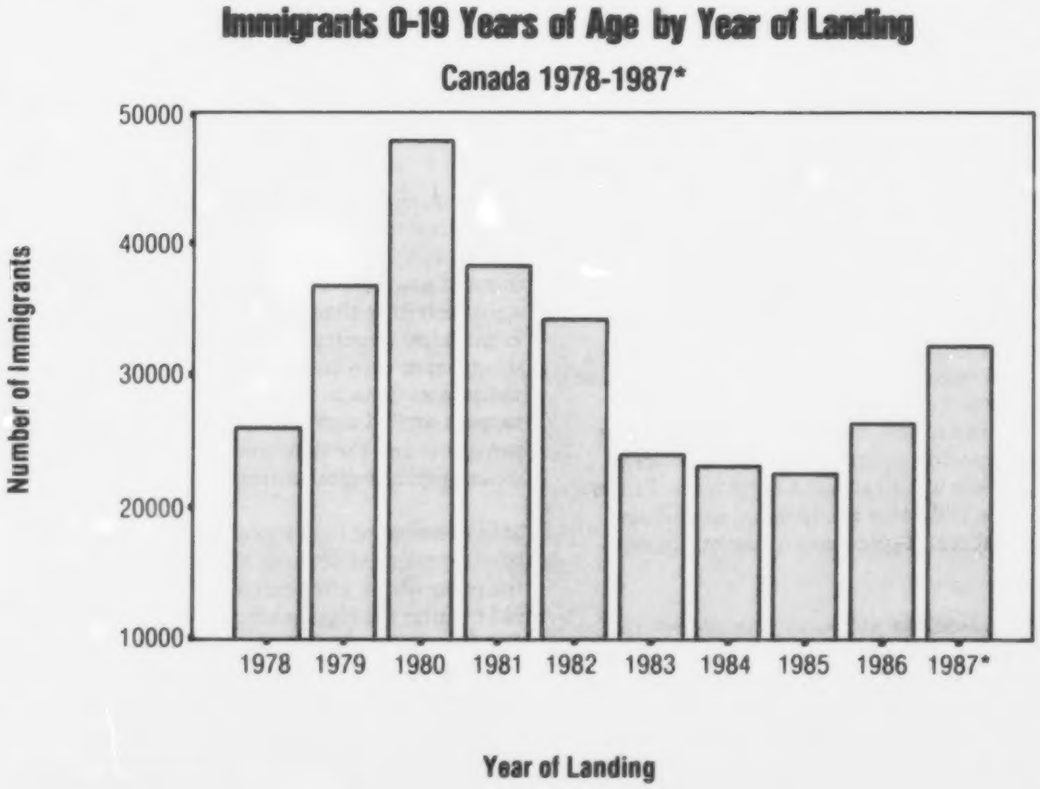
Like their peers, they must prepare themselves to be adults in Canadian society. Migrant children and youth must also transplant their roots in Canadian soil. Children's ideas of their possibilities come from experiences of success in school, from important adults, and their peers. Too often, instead of success, migrant children and youth encounter frustration because of language difficulties, because of failure of those into whose care they are entrusted to understand their needs, and because the demands of adapting to a new way of life affect children more profoundly than many adults realize.

Current Policies

Figure 9.1 documents that, on average, approximately 25,000 to 35,000 migrant children and youth enter Canada each year. As Figure 9.2 suggests, the majority are children of persons entering under the independent class, except for the 15- and 19-year-old group where the majority are family class. Presumably, people expend extra effort to bring their older children to Canada before they reach 21, the cut-off age for family class eligibility.

Canadian policy regarding children and youth emphasizes their preparation for life in a multicultural society.

Figure 9.1



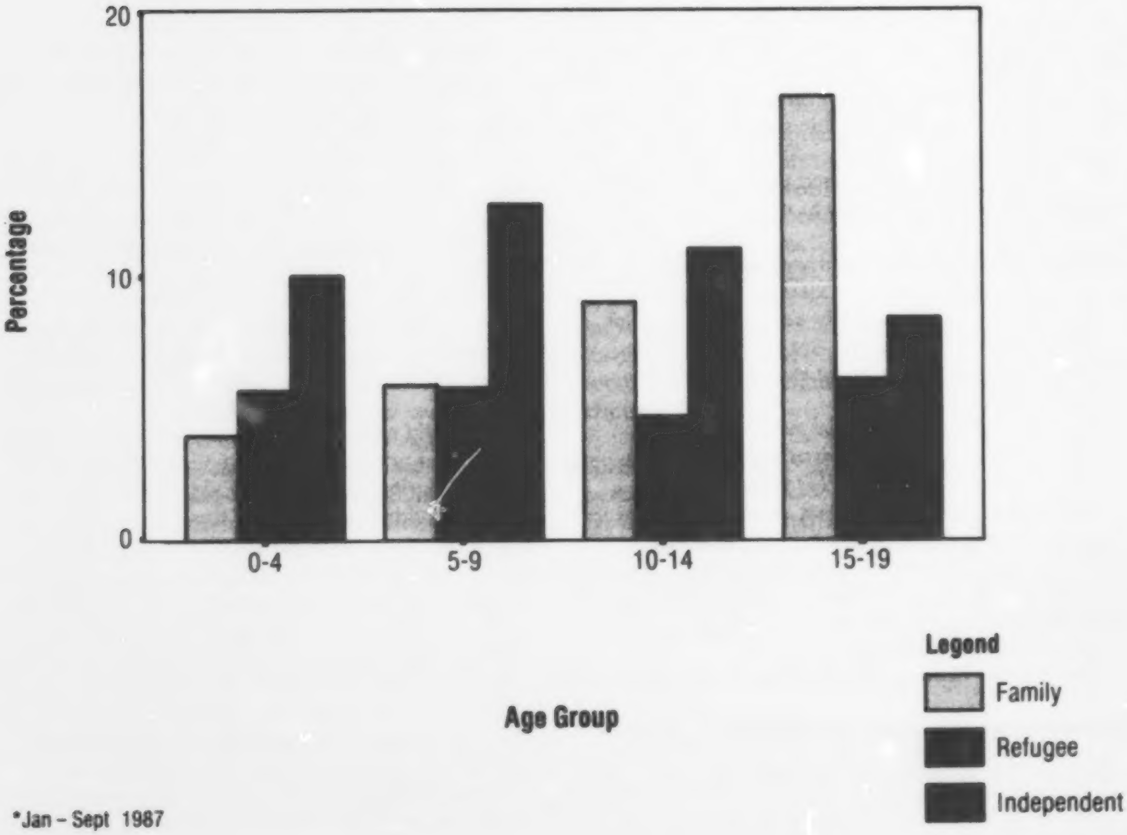
*Jan – Sept 1987

Canadian children must enjoy the right to understand and appreciate their own cultural heritage and to value the heritage and background of other cultural groups. If that is to happen, the school must do more than accept all children. It must provide early and continuing opportunities for the proud display of culture and the encouragement of understanding.
(Canada Council on Children and Youth, 1978)

Provincial legislation grants specific rights to the young in need of help and spells out the responsibilities of parents. Children whose safety and development are in jeopardy may be removed from their families; in extreme cases, they may become wards of the government and become eligible for adoption or foster home care.

Figure 9.2

Distribution of Immigrants 0-19 Years of Age by Age Group and Class
Canada 1978-1987*



*Jan – Sept 1987

Education falls under provincial jurisdiction.

Children of migrant families comprise varying but increasing percentages of public school populations throughout the country. Estimates range from 40 per cent in Montreal to 90 per cent in some inner-city schools in Vancouver. School boards across the country are establishing policies and procedures which support cultural diversity and the rights of minority groups (Roe, 1982).

For example, a Vancouver School Board policy enunciated in 1982 specifically condemns racism and states an intention "to respond actively and decisively to issues of racism in teacher training, education policy and reading materials, and in the various levels of government and in the community."

However laudable it is to condemn racism, to support cultural diversity and to emphasize the rights of minorities, pre-school and school programs must also fulfill their primary mission — to educate children. A submission from the same province which produced the admirable statement about racism — British Columbia — illustrates that policies have not yet addressed the needs of migrant children as comprehensively as necessary.

> *There is no coordinated approach within or without the school system to meet the needs of three- to four-year-old children who do not speak English at home. The (B.C.) School Act (1979) precludes school boards from providing services to children under the age of five years....*
> *The School Act states that the public education system shall provide all children with an equal opportunity for education. The underlying assumption is that all children enter school understanding and speaking the language of instruction — standard Canadian English. No mention is made of children who speak other languages or of how they can have an equal opportunity for education.*
> *(Submission: Vancouver Health Department)*

Stress: At Home and at School

A caring society must care for its children. This is reason enough to focus on children and youth as a special needs group. In addition, caring for the mental health of children is an effective way of preventing emotional disorders later in life.

The mental health professions in North America have ignored children, joining with conventional wisdom in the mistaken belief that children "grow out of it." There have been other mistakes as well. For example, until recently many authorities believed that children were incapable of becoming clinically depressed enough to require treatment. Research has demonstrated that children become seriously depressed, and many depressed children go on to become depressed teenagers. Youth who display antisocial tendencies do not grow out of it; they have a high risk of becoming antisocial or emotionally troubled adults.

The environment of the home on which they are dependent affects the mental health of children and youth. Regardless of their circumstances or motivations, immigrant and refugee families face a multitude of adjustments which are difficult to anticipate and sometimes overwhelming to resolve. Children in migrant families witness and, to a certain extent, live the problems experienced by their parents — homesickness, language problems, economic uncertainties, and painful absorption of a new culture. Because children often learn English or French more easily than their parents, and because their schools may expose them to Canadian society at a rapid pace, an unnatural role reversal sometimes results. Rather than parents being the protectors and guides of their children, the children may be forced to become culture brokers for their parents.

Parent-child relationships in migrant families, as one submission notes, are "not simple and easy." Besides sharing in their families' uncertainties, migrant children are exposed to a host society which, by comparison with their everyday lives, seems seductive and glamorous.

> *(They learn about) life through TV programs, in daycare centres and from other children in the neighbourhood. Wanting to be part of their Canadian peer group, they demand typically North American toys and food. They identify with TV heroes, ask their parents about values of the host society which are inevitably transmitted to them, or about their physical appearance as well as about their pronunciation and accent. For example, one Vietnamese three-year-old girl asked her Buddhist mother about Jesus and a young four-year-old Haitian boy ordered his mother to*

> ***wash him well because he felt dirty as a black boy. The gap between parents looking back to their past country and roots and the children looking forward stretches little by little.***
> ***(Sabatier)***

The self-esteem of the Vietnamese girl and the Haitian boy in these examples has been eroded by racism, a racism which teaches them that to be what they are is inferior. The girl will quickly learn that she can never divest herself of her Buddhist mother, and the boy that he can never shed his black skin. The realization that they can never become what they are being taught is the best thing to be breeds frustration, which may lead to symptoms of emotional disorder or to antisocial behaviour later in life.

Young children are most likely to experience the effects of prejudice in schools and pre-school settings, often from their peers. While there is widespread belief that small children are free from racist attitudes, research demonstrates that, by the age of four, children have developed a concept of race and are capable of thinking that people who are racially different from the dominant group in society are inferior.

Racism can be reinforced, not only by malicious acts of commission, but through apparently innocent acts of omission.

> ***Teachers and parents usually avoid discussing racism or deny its existence. This behaviour is supported and encouraged by the fact that neither racism nor positive cultural differences are discussed in the vast majority of classes and texts on child development and early childhood education. Such behaviour may, in fact, actually reinforce racism. For instance, a white child may object to sitting next to another child because of the child's race. And the teacher may ignore the statement or say only, "Don't say that! It isn't nice." If nothing is done to reestablish the self-esteem of the child of colour and to change the white child's behaviour — that's not just avoiding the issue, it's reinforcing racism.***
> ***(Council of Interracial Books for Children, 1983)***

Teachers may also display prejudice without being aware of it. For example, research demonstrates that white teachers often excuse disruptive behaviour in young black children with descriptions such as "cute" and reassurances that the child will "grow out of it." When the same children grow older, teachers become noticeably less tolerant of disruptions created by black children than they are of similar behaviour exhibited by white children. Teachers now tend to describe disruptive black children as antisocial or delinquent and turn to other institutions, including the mental health care system, for help.

Cultural Enrichment in Educational Settings

Cross-cultural learning to combat prejudice is possible. Experience has shown that, to be maximally effective, programs should be activity-based rather than abstract, and stress commonalities among people as well as celebrate their diversity.

The Sexsmith Preschool Demonstration Project, established in British Columbia in 1981, provides an important model. Orientation, intake procedures and parent education are designed to meet the needs of families of preschoolers from a variety of cultures. The curriculum encourages all children to be "the expert" about their own culture. The program supports the use of heritage languages in the classroom and encourages parental participation in daily activities as well as during holiday celebrations. S.E.A.R.C.O.M., a self-help Southeast Asian organization in Winnipeg, provides another important model — a youth program designed to foster pride in ethnic heritage and an opportunity to retain a sense of membership in one's heritage culture.

All school programs must involve parents. School-parent interaction helps alleviate cultural tensions to which migrant children are almost invariably subjected, and which may foster conflict between parents and children. Parent-teacher associations across the country must become more culturally diverse, reflecting Canada's multicultural society.

Helping Children Learn

The way teachers behave affects the way children learn in school. Research documents the disturbing fact that majority culture teachers treat ethnic children differently from their white students. For example, white teachers encourage white children to talk significantly more and to respond to questions in a more complex way than they do ethnic children. This is important because talk is one of the most effective means teachers have of teaching both language and problem-solving. Talking about events and ideas helps the teacher comprehend the child's view of the world, a necessary step towards individualizing instructional approaches.

> *If the culture of the teacher is to become part of the consciousness of the child, then the culture of the child must first be in the consciousness of the teacher. (Bernstein, 1972)*

Talk is an important guide for teachers about how much a child knows. Talk is also a way by which teachers can teach children how to learn. Teachers who take the time to link a child's simple response to a question about events in his or her life, or to the environment of classroom or home, are engaged in the important process of helping the child learn how to use language in order to learn.

The amount of time a teacher will give a child to respond to a question, or to correct a reading error before responding with the correct answer, or moving on to another child, is an important component of instruction. The typical North American teacher waits one second or less for a child to respond to a question. Research demonstrates that waiting longer, say five to ten seconds, has important benefits: children learn how to formulate more complex responses and there are significant improvements in school performance. Some ethnic groups typically pause for longer periods in conversation or in responding to questions than persons who have grown up in North America. Children who are just learning English or French may have to translate a question in their minds before they can respond, a process which results in a response delay. For either or both of these reasons, migrant children may be passed over or corrected too quickly. Repeated experiences of this type are damaging to self-esteem and result in failure to acquire academic skills.

When teachers and other adults entrusted with the care of children understand and appreciate the children's cultural backgrounds, they perceive them more positively and expect them to progress at a higher level. This observation, supported by research, suggests that sensitizing teachers and daycare workers to culture may improve the children's chances for effective learning and maintenance of their mental health. *One Child/Two Cultures*, a manual for facilitating the integration of newcomer children in educational settings, has been compiled by the Immigration and Settlement Branch of Manitoba's Department of Employment Services and Economic Security. It provides a potentially important component of such sensitization. As well as general background about the immigrant and refugee experience, the manual provides brief descriptions of the cultures of the most prominent migrant groups in Manitoba; it touches on salient features such as education, customs, dress, naming, and forms of address, and notes the implications of cultural features for teachers dealing with children in the educational setting.

The willingness of children to ask for help depends on how they perceive their status in the classroom or daycare centre. Children who feel hesitant to engage teachers or to enter into collective activities because they feel that, as migrants, their status is marginal, do not change unless they have an opportunity to see ethnically diverse staff interacting with each other in an egalitarian way. Teachers who come from the same ethnic background also provide individual role models for migrant children; these children often cannot model themselves upon teachers from the majority culture because they feel the social gap is too wide.

Children experiencing difficulties may have to be referred for specialized help. Psychoeducational assessments are frequently compromised because the most frequently used methods, such as the Wechsler Intelligence Scale for Children, may not have been standardized for use with ethnic minority children, particularly those whose first language is something other than English. If these techniques are not used with exceptional sensitivity and skill, they may yield a distorted view of a particular child's potential. When children develop mental health problems requiring professional referral, this must be handled with great sensitivity. One must be cognizant of the perception of mental disorder in the parents' and child's culture, and the expectations parents may have of professional services. Parents may fear that, by allowing their child to enter treatment, they risk stigmatizing him or her with an unfortunate label. Or they may worry about losing their child either through actual removal or an erosion of cultural identity. Therapists should not think of themselves as agents of the host culture; they are persons whose task involves helping the child to establish a unique identity, one which must encompass his or her parents' origins as well as the culture of Canada.

Conclusions

Research to establish the extent of mental health need and the conditions creating mental health risk among migrant children and youth is much needed. Because the needs are so pressing, action to promote the emotional well-being of children and youth cannot wait for the development of definitive knowledge. There are plausible reasons to suggest that changing community attitudes, attending to the curricula of schools, and supporting youth-related programs will result in mental health benefit. Noted author V.S. Naipaul once said: "We make ourselves according to the idea we have of our possibilities" (Naipaul, 1980). In a pluralistic society, children's visions of their possibilities must not be limited by intolerance. They must be shaped by a celebration of their uniqueness.

The Task Force recommends that **Health and Welfare and Secretary of State work with their provincial counterparts to ensure that the curricula and environments of schools, preschools and daycare facilities reflect the cultural diversity of the children attending them.**

Chapter 10:

Women

The Issue

While self-help activities and lobbying efforts have been initiated on behalf of immigrant women over the past decade, significant progress has been slow. Being female does not in itself predispose to mental and emotional disorders. But, many immigrant women remain in high-risk situations due, on the one hand, to features of the cultures from which they come and, on the other hand, to Canadian policies and programs which disadvantage them.

Risk Factors

Several of the variables which increase stress at the time of migration affect female immigrants and refugees more than their male counterparts.

Among immigrants, men usually make the decision to leave a homeland. Several submissions noted that women typically emigrate to accompany or to rejoin male relatives rather than the reverse. As Figure 10.1 indicates, women entering Canada over the past decade were many times more likely than men to immigrate as dependent spouses, and much less likely to enter Canada in a category designated to participate in the labour force.

Once families enter Canada, men typically decide where to resettle. Immigrant families move to cities and provinces where the male bread-winner can find employment or where his relatives and friends have already settled. Women not only leave what is familiar more reluctantly than men; they must also resettle in surroundings which initially have less to offer them.

Separation from family members affects immigrants and refugees of both sexes, but women from traditional cultures tend to be more fully enmeshed in family networks than men and more devastated by their absence. The fact that women are also more likely to be unmarried at the time of migration further intensifies the impact of separation from relatives.

While married women enjoy the support of a family network, the burden of keeping the family together frequently falls on them.

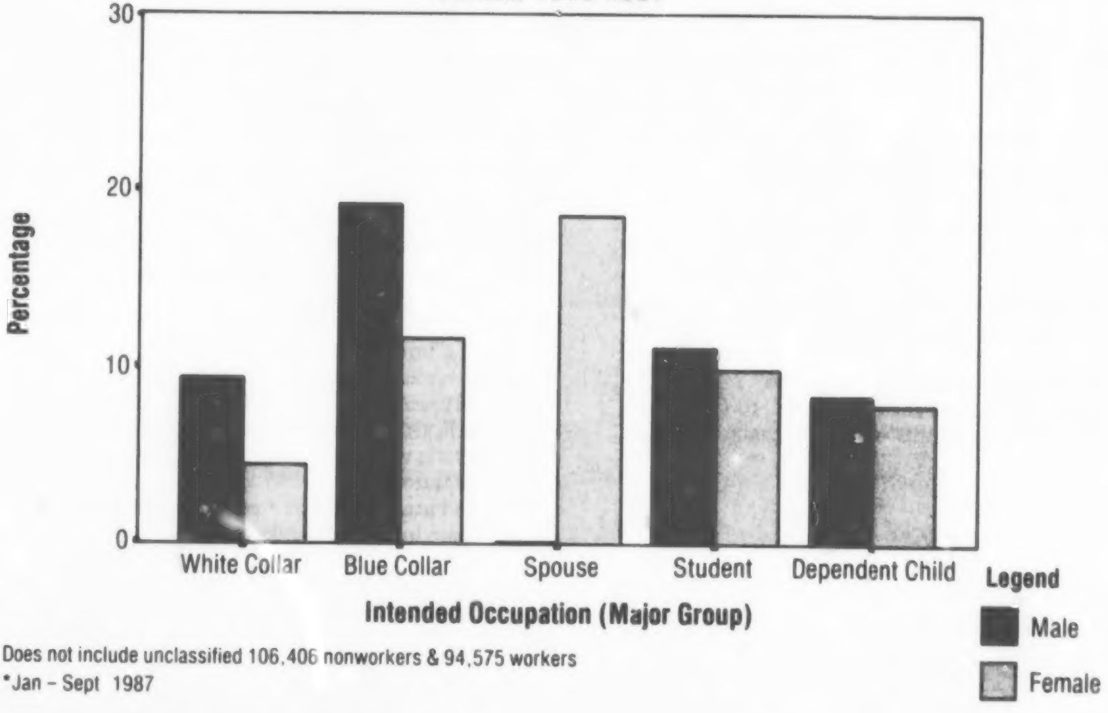
In many immigrant families, the woman is primarily responsible for supporting her children and partner as they adapt to the new country. An immigrant woman has a tremendous responsibility to keep the family together and happy, and to transmit the family's culture and traditions. Yet she must accomplish these crucial family tasks often with little or no support for herself.

An immigrant woman, already answerable for the health and happiness of her family, must also assume the male role of providing for the family. The presence of her customary support network can make the difference between survival and defeat.

Figure 10.1

Distribution of Classified Immigrants by Intended Occupation (Major Group) and Sex

Canada 1978-1987*



Does not include unclassified 106,406 nonworkers & 94,575 workers
*Jan – Sept 1987

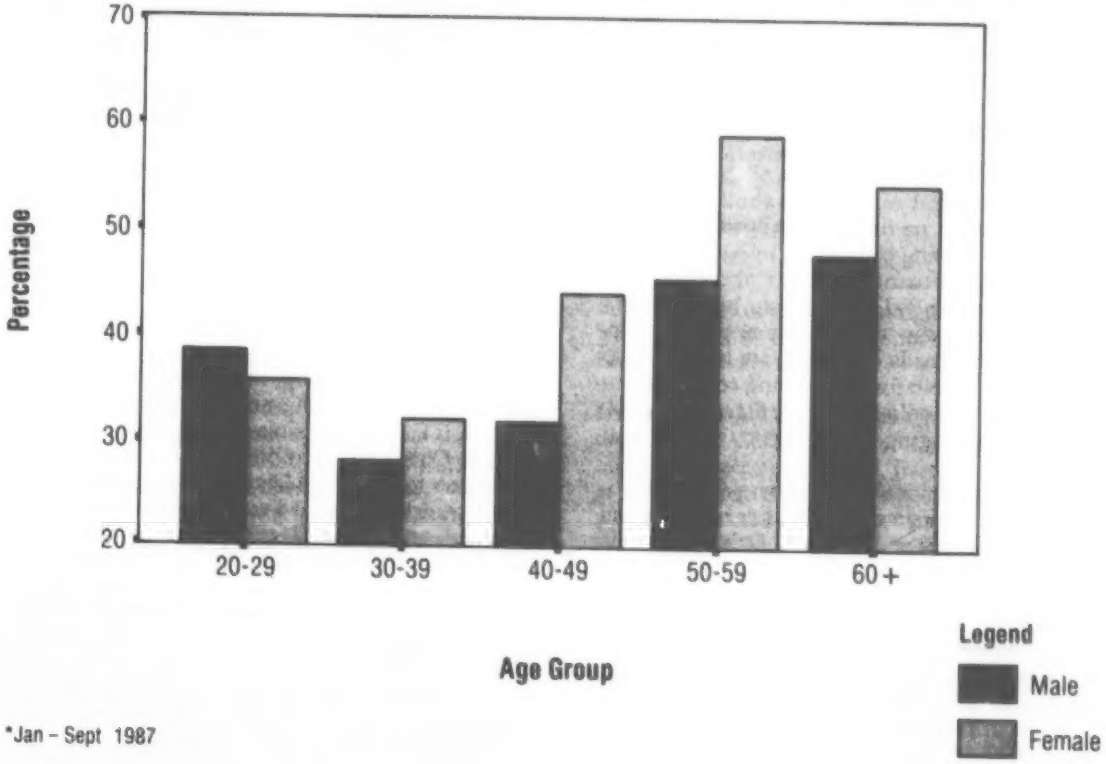
Migrants who speak one of Canada's official languages can cope more effectively with both the stresses of resettlement and the demands of the job market than those who cannot (Chapter Three). As Figure 10.2 illustrates, however, immigrant women are less likely than their male counterparts to speak French or English. Lack of language compounds the problems of resettlement and employment and deepens the dependency of women on their male relatives.

Any dependent relationship is subject to abuse and the immigrant husband-wife relationship is no exception. Although no community-based survey data are available, one analysis of clinical data revealed that over 30 per cent of women seeking help from Manitoba's Immigrant Access Service had been victims of physical abuse (Submission: Immigrant Women's Association of Manitoba). Without the traditional safeguards afforded by family networks, immigrant men are more apt to "take out their frustrations" on their wives, frustrations which usually peak when the men fail to find meaningful employment.
(Submission: O.A.S.I.S.)

Figure 10.2

Percentage of Male and Female Immigrants in Adult Age Groups Who Speak Neither Official Language

Canada 1978-1987*



*Jan – Sept 1987

The association between employment problems and marital problems applies both to Canadian-born and migrant populations. For migrants, however, either problem appears less remediable. If a migrant wife finds work — and migrant women are more likely than Canadian-born women to be in the labour force — she will probably receive a very low income, lower than that of migrant men or Canadian-born women (Submission: Ottawa-Carleton Immigrant Services Organization, 1985). Furthermore, her wage-earning role may deepen her husband's sense of failure and actually foster rather than alleviate marital discord.

The factors which create dependency in migrant women and permit abuse to occur also prevent women from escaping abuse situations (Wiebe, 1985). Cultures which socialize women to dependent roles also limit the circumstances under which they may leave their husbands. In the absence of her parents or other important family, a woman may be more vulnerable to abuse; she is also blocked from the one traditional escape route — back to her family — that she may know. Inability to speak the language of their new society reinforces immigrant women's dependency on men. It also prevents them from using and comprehending information or services which might assist them in either correcting or leaving abusive situations.

Language disability and ignorance of Canadian law lock many immigrant women into abusive work situations. Women are occupationally segregated, often employed doing piece-work in factories or in domestic service, situations which make them vulnerable to abuse and exploitation. In particular, women who must support children or other dependents, either in Canada or abroad, are highly vulnerable to exploitation in working conditions, hours of service, employment benefits, and salary. (Submission: Changing Together)

Women from traditional cultures who are locked into marginal employment with other migrants and women who are unemployed have little opportunity to learn a new language.

> *We are from societies where "men and dogs roam, while women and cats remain at home." Unable to communicate fluently, the woman's apartment soon becomes her prison.*
> *(Submission: Immigrant Women's Group of P.E.I.)*

Over time, if her language disability remains constant, the isolation of an immigrant woman increases, tragically with respect to her own children who, sooner or later, do acquire English or French and may become unable or unwilling to speak their heritage language (Submission: Medicine Hat Society for Immigrant Settlement).

Mitigating Policies and Programs

Since the factors which create stress for migrants apply particularly strongly to women, policies and programs which address these factors are of even greater importance for women than for men.

Orientation services assist migrant women in fulfilling their central role of shepherding family members through daily life. Many women, however, are unable to participate in orientation programs if they are offered only in English or French or if they do not offer childcare. Upon their arrival in Canada, refugee women are told that they may attend the initial orientation session only if they are the heads of households.
(Submission: Working Women Community Centre)

Family reunification holds great significance for immigrant and refugee women, as do community development initiatives which help recreate culturally familiar and approved social support networks. In rural areas and regions with few immigrants of the same cultural background, offers of friendship between immigrant and Canadian-born women are particularly important. (Submission: United Church of Canada) At present, however, CEIC's Host Group Program applies only to refugees.

Official language training, the key solution to the problem of non-English or non-French-speaking persons, is far less accessible to women than it is to men. As Chapter Three notes, basic living allowances for Labour Market Access Language Training are not provided to members of the Family Class and Assisted Relatives. Since a majority of such persons are female (Figure 3.1) and because their income, however meagre, is often critically necessary, many migrant women never receive language training.

In the past decade, the problem of language education for women has been well documented in several studies and reports, and the same recommendations have been made repeatedly.

In 1981, the First National Conference on Immigrant Women (Toronto) recommended universal access to language training with childcare and transportation allowances.

In 1985, a national consultation commissioned by Multiculturalism Canada identified language training as the most urgent priority for immigrant women (*Beyond Dialogue*, 1985). In the same year, the Action Committee on Immigrant and Visible Minority Women again called for universal access to language training.

In 1986, the Annual Report of the Canadian Human Rights Commission noted that immigrant women are discriminated against in the provision of language training.

Briefs presented to this Task Force in 1987 suggest that little has changed; the need for universal access to language training is as great as ever.

For many migrant women, access to language training programs, like orientation programs, depends upon child care facilities as well as reimbursement for child care expenses.

> *The most immediate need for day care is for the Canada Employment Centre's English as a Second Language program ... Although a child care allowance is provided, few immigrants are able to find day care spaces. The natural and logical solution to this problem is on-site day care or rented services from existing day care centres to observe and serve all immigrant children upon arrival.*
> *(Submission: Coalition for Immigrant Women in Nova Scotia)*

Several submissions reiterated and endorsed the suggestion that language training for parents and preschool children be offered together, at the same time and in proximity to one another (Chapter Nine). Programs such as those offered by the Centre local des services communautaires Côte-des-Neiges, are preventive in both the short and long term.

> *These programmes are preventive as they address the issues of linguistic (and therefore social) isolation of ethnic families. Furthermore, they are possibly reducing the risks of "parental children" who evolve as culture brokers interfacing with the host culture on behalf of their parents.*
> *(Submission: Guzder)*

After language training and employment opportunities, learning about women's roles and women's issues in Canada is of vital importance.

> *For Moslem women in particular, it would be most useful to establish specific programs with discussion groups on subjects of common interest to this clientele, such as divorce, childbirth, conflicting values, spouse abuse, etc.*
> *(Submission: Centre Maghrebin de Recherche et d'Information)*

Briefs from every region of Canada and virtually every ethnic group responding to the Task Force expressed a need for accurate information, and understanding of Canadian customs and laws as they apply to women. In particular, a woman's rights in Canada, both as a wife and as an employee, require in-depth clarification and discussion.

A misconception held by many is that individuals who migrate as dependent spouses will be deported if they leave their homes due to marriage breakdowns. In 1986, Employment and Immigration Canada attempted to dispel this and other myths by distributing a fact sheet on "Battered Immigrants and Immigration Status." As the submissions to the Task Force indicate, however, if it is to have the desired effect, such information must be delivered sensitively and personally, in a language understood by each woman.

Conclusions

For a number of reasons, immigrant and refugee women have, on the whole, more mental health needs than their menfolk.

Immigrant women suffer two types of educational disadvantage. Some are extremely highly educated but many more are illiterate. Barred from many jobs, the higher educated are prone to underemployment and the illiterate to dead-end jobs. They are also more likely to be cut off by migration from traditional sources of support, and to be constrained by tradition from developing new support networks. Despite these limitations, immigrant women rather than men are the ones most likely to be held responsible, and to feel responsible for the health and happiness of family members.

Immigrant and refugee women also tend to have special needs because of the differential impact on males and females of CEIC's official language training policy. By excluding members of the Family Class and Assisted Relatives from language training with basic living allowances, the policy obliges many women to cope with resettlement, enter the work force, and raise their children with little comprehension of the new world around them and less ability to communicate with it.

The higher incidence and intensity of risk factors, and the reduced access to mitigating factors, create special mental health needs for immigrant and refugee women.

Without exception, the recommendations made by the Task Force elsewhere in this report stand to benefit migrant women at least as much as immigrant men. In particular, implementation of the recommendation that all newcomers have equal access to official language education will significantly ease the stress of resettlement for women. It will also help break the vicious cycle of no language training leading to marginal employment, which in turn makes learning a language impossible. The result is that, without language, there is no chance to break out of the marginal employment situation. Finally, ability to speak English or French will decrease women's dependence on their husbands, employers and children; it will give women some measure of control over their own lives.

Chapter Five's recommendation concerning educational materials for immigrants on mental health issues and services is also of special relevance to women, the persons traditionally responsible for family members' well-being. Similarly, Health and Welfare's prioritization of immigrant Health Promotion activities will result in mental health programs to assist women (Chapter Six).

Beyond the needs met by these recommended policies and programs, the Task Force recognizes a need for immigrants and refugees of both sexes to know and understand Canadian laws and customs pertaining to women. It recommends, therefore, that **Health and Welfare, Secretary of State, and Status of Women Canada develop and provide multilingual educational materials on women's rights and roles in Canada for discussion at immigrant service agencies, general community service agencies and ethno-cultural organizations.**

Chapter 11:

Seniors

The Issue

The longer one has lived in and with a culture, the more difficult it is to change it for another. Because of this, immigrant and refugee seniors are particularly prone to stress and an increased risk of mental health problems during resettlement.

Senior migrants have virtually no peer group infrastructure or advocacy base to assist them in Canada. They exist as an isolated minority within each ethno-cultural community, depending heavily on younger relatives for financial, social and psychological support.

Senior immigrants and refugees need social and health services, and these must be accessible to them. In addition, ethno-specific support programs must be provided to meet the mental health needs of elderly newcomers.

Context of Aging

Over the past decade, about 10 per cent of all immigrants entering Canada have been 60 years of age or older. Only three per cent of Task Force submissions, however, focussed on elderly immigrants or refugees. As one research worker stated, "Seniors are the most powerless, least influential, and most 'forgotten' segment of the ethnic population" (Disman, 1986).

While Canadian-born seniors are also relatively powerless, living in Canada has partially prepared them to expect a loss of status as they age. By contrast, many cultures bestow increased honour and decision-making power on aging individuals. Seniors from such cultures face a major discrepancy between the status accorded the elderly in their countries of origin and what they find when they reach Canada.

With very little official language ability (see Figure 10.2) and few compatriots their own age, many seniors must depend on younger relatives, usually their grown children, for social interaction and support. Their lack of language and lack of understanding of the larger society limits their participation in general community programs for seniors.

Most important, migrant and Canadian-born seniors alike have less capacity to adapt to new environments than do their younger counterparts. Elderly immigrants, however, must face entirely new physical and cultural surroundings. They do so, not only with less adaptive capacity than younger newcomers, but also with less education (Figure 11.1) and presumably with less understanding of their new environment.

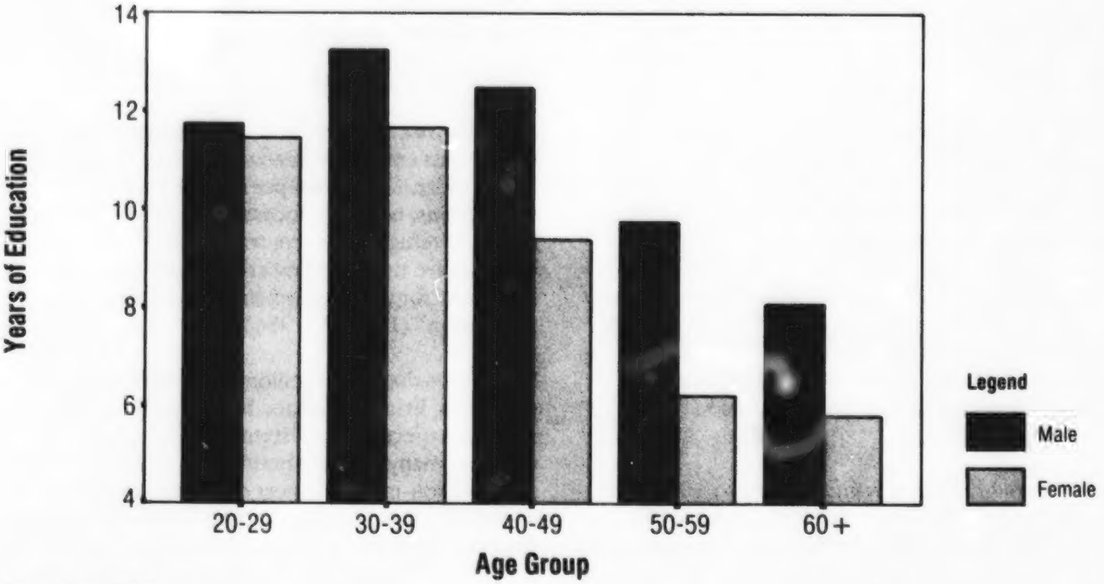
The demoralization that accompanies loss of status, the isolation imposed by limited linguistic skills, and the alienation from a culture to which others are adapting results in elevated mental health risk.

The potential for demoralization lies primarily in the interpersonal dynamics of immigrant family life and in the ways these contrast with family dynamics in the countries of origin. In Canada, elderly parents usually come to live in the homes of their married children: in the home country, it is often the reverse. When they do live in their children's homes, the elderly are often expected to do housework and to look after grandchildren, rather than, as would be the case in their home countries, to supervise household affairs. As the children and grandchildren adopt Canadian customs and values, the wisdom and experience of their elders becomes irrelevant, and their advice is neither sought nor heeded.

Figure 11.1

Average Years Education of Male and Female Immigrants in Adult Age Groups

Canada 1978-1987*



*Jan – Sept 1987

Whether or not senior immigrants should live with their grown children is a difficult decision for both parties. Seniors themselves may feel that the isolation of living on their own is preferable to the demoralization of living with family members who fail to accord them their traditional status. A survey of five ethnic communities in London, Ontario found that, especially among seniors from China and Vietnam, multigenerational families were no longer seen as ideal.

> *Figures indicated that 50 per cent of seniors would prefer to live on their own if they were able to do so. Estimates made by a similar survey in Toronto put the figure at closer to 80 per cent.*
>
> *Value changes occurring between the generations of a family is exacerbating the trauma, reflected in...the expressed problems of caring for seniors when both husband and wife work.*
> *(Submission: London Cross Cultural Learner Centre)*

For their part, grown children may find that living with unhappy elders who cannot accept new ways is emotionally more costly than living with the guilt of not housing them. In an unknown number of instances, financial costs also weigh in the decision, particularly since newcomers are ineligible for Old Age Security until they have resided in Canada for 10 years.

> *Immigrant family breakdown is demonstrably increasing, with the stress of poverty exacerbating the pre-existing tensions in a multigeneration family. Younger members of the family, faced by the challenge of finding their own way in a new environment and in a generally difficult economic climate, sometimes find it expedient to force seniors out of the house so that they may be more fully supported by the welfare system.*
> *(Submission: London Cross Cultural Learner Centre)*

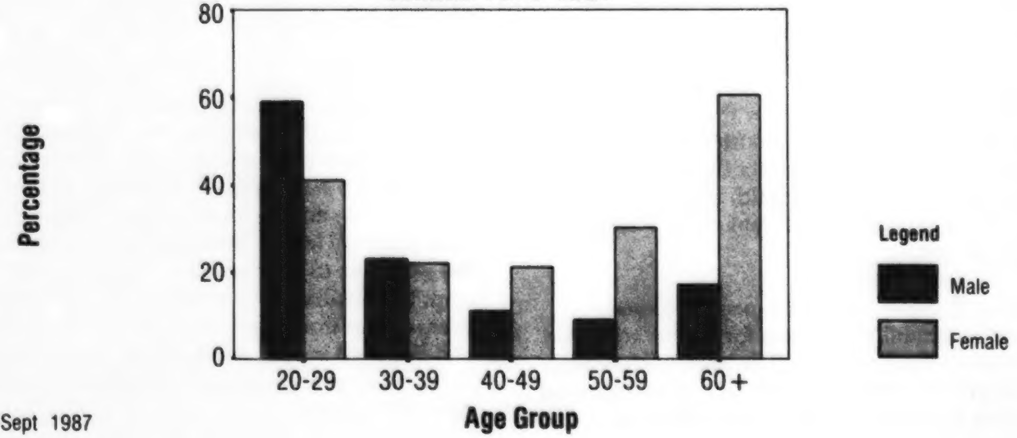
Many elderly immigrants, particularly women, who leave the homes of their younger relatives, live in poverty and isolation, often without a spouse (Figure 11.2). Few ethno-cultural communities are large enough to have groups of seniors living within visiting distance of each other. Moreover, the idea of deliberately developing programs or services for seniors is foreign to many cultures.

Alienation from Canadian values and customs can affect elderly newcomers whether or not they live with family members, depending on how rapidly the family members acculturate. The issue of Canadian citizenship often symbolizes and concretizes the problem.

Figure 11.2

Percentage of Male and Female Immigrants in Adult Age Groups Who Are Unmarried

Canada 1978-1987*



*Jan-Sept 1987

> ***In many cases entire families will be granted citizenship, except for the older person who has not learned English [French] and therefore cannot answer questions at the hearing... Many older people feel alienated and useless to their families because they are not able to obtain citizenship. (Submission: Intercultural Task Force)***

Although younger immigrants may not, in fact, care about the citizenship of their elders, they are often critical of the lack of change in their diet, dress, and social or religious behaviour. For the elders, changes in these areas are especially disturbing. Inability to engage in customary religious events and rituals, for example, deprives them of a main source of comfort in their declining years.

Sources of Assistance

Submissions to the Task Force suggest, as does the research literature, that the problems of senior immigrants and refugees have been identified in Canada and elsewhere, but very few solutions to problems have been implemented.

Considered collectively, the services for immigrants funded by CEIC, Health and Welfare and Secretary of State focus on all age groups except for the elderly. CEIC's Settlement Language Training Program (STLP), which includes people who are not destined for the work force, should theoretically attract and help elderly migrants. In reality, however, few elderly people can learn English or French in a curriculum geared to the young. Health and Welfare's New Horizons program funds a wide range of initiatives undertaken "by seniors for seniors." Since ethnic communities tend not to have organized seniors' groups, however, few such groups have received funding. Projects concerned with ethnic elderly reported by the Intercultural Task Force in Halifax-Dartmouth and by the London Cross Cultural Learner Centre and funded by Secretary of State and Health and Welfare, respectively, represent important exceptions to the overall picture.

Insufficient effort has been expended to make general community programs for seniors accessible to a multicultural clientele. The relatively low numbers of ethnic elderly and their lack of an organized advocacy base help to explain the difference. As noted in several presentations to the Task Force, there also is a perception on the part of some service providers that immigrant seniors require fewer services, and that their lack of utilization can be explained by the care afforded them by their families and ethnic communities.

Studies conducted in Nova Scotia and Ontario on a wide range of ethno-cultural communities suggested that, rather than having fewer needs, immigrant seniors seek out services as much as or more than the Canadian elderly. For example, in comparison to a Canadian-born control group, immigrant seniors utilized the services of general practitioners considerably more often and for a wider range of needs, including counselling needs. They were, however, less likely to complete a sequence of care. Whereas Canadian-born seniors tended to see "a direct path from general M.D. to specialist," elderly immigrants frequently failed to follow through on referrals to specialists or to general community auxiliary programs (Submission: London Cross Cultural Learner Centre). Consequently, hospital out-patient and emergency services saw a disproportionate number of immigrant seniors in crises. This pattern was exacerbated by the fact that younger relatives of elderly immigrants tended to view acute care in institutions as more acceptable than chronic care programs.

During a February 1988 Canadian Public Health Association conference on ethnicity and aging in Ottawa, approximately 140 ethnic minority seniors, government bureaucrats, and non-governmental service providers discussed a range of preventive and remedial measures that could address the special needs of Canada's ethnic elderly, especially the need for culturally appropriate housing and social support services.

One of the most important outcomes of the conference was the realization by all participants that there are seniors who have the ability and interest to work towards the resolution of the problems they and their peers face. In some cases, these potential leaders immigrated as younger adults and were able to learn an official language and adapt to Canadian culture before old age. In other cases, seniors from less traditional cultures or those who had lived in former colonies of the western powers were able to interpret Canadian customs and values for others.

Conclusions

The loss of what is familiar, and the difficulty in incorporating a new way of life place many elderly immigrants and refugees at high risk for emotional problems and mental disorders. The unexpected loss of status within their own families leads to demoralization. Social and psychological isolation grows as younger relatives acculturate, and peers, already few in number, die. Unable to adapt, seniors remain alienated from their new environment and may become alienated from their children.

Their special needs limit the extent to which seniors can benefit from recommendations made elsewhere in this report. Initiatives regarding employment opportunities, for example, and language training hold out considerably less promise to seniors than to younger adult migrants. On the other hand, multilingual orientation materials, particularly in non-print media, are of vital importance to seniors both before and after migration.

Recommendations concerning the accessibility of general community social and health services will assist elderly immigrants at least as much as younger ones, providing that programs and services designed specifically for seniors respond as positively as some other age-focussed programs have. For many senior immigrants, the availability of well-trained, culturally sensitive interpreters is the most essential component of service delivery.

Elderly immigrants and refugees stand to benefit from community development initiatives such as those undertaken by Secretary of State with regard to leadership training and self-help group development (Chapter Two). Peer group "networking," a combination of social support and activity, is sorely lacking for many immigrant seniors. It is also very much desired by them since, in many cultures, it is familiar and acceptable. The potential leaders and role models are available; they need only be encouraged and supported to realize the potential of their skills and ideas.

The Task Force recommends that **Health and Welfare and Secretary of State encourage and support the development of seniors' support groups and programs in immigrant service agencies, general community service agencies, and ethno-cultural organizations**. Funding for initial identification and training of leaders, for transportation and escort services, and for recreational activities should be included.

Elderly migrants have a wide range of needs and a wide range of abilities. By encouraging and supporting peer group development, the special needs of seniors can be met by encouraging and utilizing their strengths.

Chapter 12:

Victims of Catastrophic Stress

The Issue

People who have experienced catastrophic stress — whether natural disasters like earthquakes or floods or man-made assaults such as harassment, threats, warfare, rape or torture — bear wounds which require special compassion and understanding. The American Psychiatric Association official nomenclature, DSM-III, makes explicit note of symptoms of disorder following a psychologically traumatic event that is outside the range of usual human experience in its description of the "post-traumatic stress disorder." The essential features of this disorder include a re-experiencing of the event through painful, intrusive recollection, recurrent dreams or nightmares, feelings of being detached or estranged from others, loss of the ability to become interested in things which a person had previously enjoyed and problems dealing with intimacy. Some survivors also display hyper-alertness, difficulty falling asleep and suspiciousness in their dealings with others. In some instances, the symptoms may emerge a short time after the trauma; but delays of months or even years are not uncommon.

Even if they have not experienced the catastrophe directly, families and children of someone who has been persecuted or tortured develop wounds of their own. Studies of children in families subjected to political persecution in Latin America and in Northern Ireland, and children whose parents survived Nazi concentration camps, suggest some common behavioural outcomes. Arrest of normal psychological development, during which fear replaces the feeling of being protected, is a common, basic response. As a result, the children develop symptoms such as social withdrawal, chronic fears, depression, clinging and overly dependent behaviour, sleep disturbance, physical complaints, school problems and difficulties in getting along with peers.

Adult survivors of catastrophe are a group at high risk for developing emotional disorder. Table 12.1, documenting the use of community mental health groups by different ethnic groups in Vancouver, illustrates this. In 1987, Anglo-Canadians made up about 68 per cent of the population of the community served, while 81 per cent of the mental health services' clients were Anglo-Canadians.

Anglo-Canadians were, therefore, slightly over-represented in the caseloads. As is common for many ethnic groups, South Asians and Chinese were under-represented. However, Latin Americans and Vietnamese — ethnic groups which have been exposed to such catastrophic stresses as war, internment and torture — reversed this trend, with utilization rates far in excess of their proportions in the general population.

Recovery usually depends on the ability to re-experience the event in a protected atmosphere, to fully understand its meaning and to share it with other people. Unfortunately, fear and shame often make people reluctant to tell their stories. When they do, they are sometimes discredited. Many observers have commented on the seeming impassivity with which people recount horrifying experiences of persecution, harassment, and torture. The listener who does not realize that "psychic numbing" is, in fact, part of the disorder and may be the only way people can live with the memory of unimaginable horror, may misinterpret stolidity as evidence that the unimaginable never happened.

Table 12.1

Relative Utilization of Community Mental Health Services by Selected Ethno-Cultural Groups

	Percentage in Catchment	Percentage in Caseload	Utilization Rate	Relative Utilization by Minority Groups
Latin America	0.27	0.93	344.4%	289.4%
Vietnamese	0.39	0.58	148.7%	125.0%
South Asian	3.66	2.03	54.5%	45.8%
Chinese	13.08	7.57	57.9%	48.6%
Anglo-Canadian	68.00	81.00	119.0%	(100.00%)

* Adapted from R. Peters, ''The Interagency Mental Health Council's Committee on Multiculturalism and Mental Health: Progress Update,'' Greater Vancouver Mental Health Service Society, February 1988.

Calling a reaction post-traumatic stress disorder, and pointing out that it can occur in previously healthy people exposed to many different types of catastrophe, must not blind us to the fact that each individual reacts to stress in a unique way. That uniqueness is in part shaped by culture. For example, some authorities have reported that a Latino man, who had been tortured and broken under the strain, suffers the humiliation of having betrayed his cultural ideal of manliness in addition to suffering the effects of the torture itself. On the other hand, so many Cambodian women suffered rape and torture that the stigma may be less than it is for other groups; there is a tendency to interpret the experience as fate.

The Special Case of Torture

In 1973, the medical committee of Amnesty International recommended studies to validate the impression that the use of torture by repressive regimes was widespread, and to determine the effects of torture. The first centre for the treatment of victims of torture was established in Copenhagen in 1982. But the Canadian Medical Group of Amnesty International had begun investigating torture and its sequelae earlier. The work, which began in Toronto in 1978, culminated in the establishment of the Canadian Centre for the Rehabilitation of Victims of Torture in 1984. To date, the Centre has worked with over 800 victims of torture, 200 during 1987 alone. A second centre, the Vancouver Association for Survivors of Torture, began in 1985.

Both Canadian groups agree that the goal of torture is to destroy personality, not to extract confessions. Their conclusions echo the eloquent comments of Elaine Scarry:

> *Pain ... is a vehicle of self-betrayal. Torture systematically prevents the prisoner from being the agent of anything and simultaneously pretends that he is the agent of some things. Despite the fact that in reality he has been deprived of all control over and therefore all responsibility for this world, his words, and his body, he is to understand his confession as it will be understood by others as an act of self-betrayal.*
>
> *The goal of the torturer is to make one, the body, emphatically and crushingly present by destroying it, to make the other, the voice absent by destroying it. (Scarry, 1985)*

The common psychological sequelae of torture are evidence of the effectiveness of the torturers' methods.

The Toronto Centre for the Rehabilitation of Victims of Torture reports that suspiciousness is a common characteristic of all survivors of torture. Suspiciousness combined with hyper-alertness to stimuli causes them to misinterpret stimuli, sometimes with severe consequences. For example, the director of the Centre reports that it is not uncommon for a survivor of torture to be awakened by the sound of a car idling, misinterpret this as evidence that he or she is under surveillance, and develop a panic attack. People who have been persecuted are particularly vulnerable to racism because of fear that, to people in a vulnerable situation, the unmentionable could happen again. Victims of persecution and torture are hypersensitive to rejection and prone to over-react to situations they commonly encounter, such as bureaucratic delay.

Providing help for survivors of torture is complicated by the fact that many are reluctant to come forward. Many are understandably suspicious of helping agencies like mental health clinics; their experiences with helping professionals like physicians may have included examinations which resulted in an opinion that they could withstand more torture. Survivors also suffer a burden of shame and a fear of hurting their families through their revelations. Shattering as the statistics gathered by the Toronto centre are, they likely are substantial underestimates of the extent of the problem.

The reluctance to seek help is unfortunate because accumulating evidence suggests that the therapy is very effective. Many torture victims can be helped by psychotherapy. The act of testimony, of sharing painful and humiliating experiences with another person, has significant therapeutic value for victims of torture and political repression. Through testimony, bewilderment may change to anger against the torturers and the regime which countenanced the acts. Some torture victims have found relief by transforming their private suffering into public testimony, thereby helping others and becoming part of a constructive social force to combat the use of torture. Public testimony, besides contributing to the common good, has been found to have a therapeutic effect on the individual, helping him or her to channel hostility in a positive way. Performing an act of social reparation brings psychological relief.

This form of testimony, which imparts a value to the person's suffering, transforms a passive experience into an active response.

Survivors of persecution and torture often experience particular difficulty in vocational and social rehabilitation. Traumatic dreams and hyperalertness often result in sleeping difficulties which in turn makes it difficult for them to get to work on time or to concentrate on tasks. In response to their special needs, CEIC has funded a project for the vocational rehabilitation for survivors of torture.

The Task Force lauds the efforts of the Toronto and Vancouver centres to focus attention on a largely hidden problem which creates pain and suffering for many, and the attempts by CEIC to provide flexible programs to meet some of their needs.

The Task Force recommends that **Health and Welfare support research and health promotion initiatives to delineate the psychological consequences of torture and to develop effective treatment modalities for survivors of torture and their families.**

Part V

Conclusions and Recommendations

The Task Force heard many dramatic stories about the experiences of immigrants and refugees in Canada. The following account illustrates only too well the health issues affecting many of our newcomers.

When Quyen heard the news about her brother, she allowed herself to think there might, still be reason to hope. In 1981, Quyen and her husband, Bang, sharing the load of their infant daughter between them, followed the lead of Quyen's older brother and fled Vietnam. They never caught up with him. However, someone in the refugee camp in Thailand told Quyen her brother had been there before them; he had been selected as a refugee and had left for Canada. By the time Quyen and her husband arrived at the camp, Canada had stopped taking refugees in large numbers and they were forced to wait.

The filth of refugee camp life, and the overflow from the latrines which ran over the paths between the overcrowded concrete warehouses where they lived, depressed their spirits. Bang felt he had to constantly stay at his wife's side. Other slender, pretty women like her had been raped behind the garbage cans where they scrounged for extra food, or in one of the camp's dark alleyways. The birth of a second child — even though it was a boy — made them feel even worse. Then the miracle happened. The Canadian embassy located Quyen's brother living in a small community in British Columbia; he reported that in a year or so he would be financially able to sponsor them to come to Canada.

In fact, it took longer than a year for him to accumulate enough money to convince the government that he could be financially responsible. By December 1985, the family was on its way to Canada and a new life. They were overjoyed to learn that Quyen's brother had found a job for Bang in a mining town in the northern part of the province, about 160 km from where he was living. They stayed in Vancouver long enough for Bang to complete a language training course for persons bound for the labour force and then left for northern B.C. As soon as they arrived in their new home, Quyen's brother called to say he was driving over to greet them, to see the niece he had known only as a baby and the nephew who was still a stranger.

The newspapers that evening reported that a two-car collision on the Trans-Canada Highway had resulted in the death of a 40-year-old Vietnamese man.

Bang's face never lost the serious, troubled look acquired in the refugee camp. He worked hard in the mine and soon found a job washing dishes as well. He was ambitious and, even though working six days a week, 12 hours a day kept him away from his family, he hoped this would only be temporary. In the long run, he hoped it would provide the financial advantage they needed. Because he was away so much and exhausted when he did come home, Bang did not notice that his wife tended to blame herself more and more for her brother's death. Nor did he realize that she was becoming despondent and apathetic.

Quyen could not stop thinking that, if not for her, her brother would still be alive. She also was unhappy about being the only Vietnamese adult in the small town. Bang now spoke some English and the children were picking it up quickly. Quyen would have liked to learn the language too, but did not qualify for any of the training programs offered in the area. Even if she had, there would have been no one with whom to leave the children — certainly not the neighbours who seemed so unfriendly.

Her neighbours not only were unfriendly; they were disapproving. They had noticed that Quyen sometimes left her nine-year-old daughter alone with the five-year-old brother while she went to the store. They also noted that, even when Quyen was home, the children seemed remarkably free to roam the neighbourhood and cross streets without adult supervision.

Quyen did not feel well. One day, she went to see a general practitioner whom Bang had heard about at work. Using her daughter as the interpreter, Quyen explained to the doctor that she was having spots in front of her eyes, that she felt tired all the time but couldn't sleep at night. The physician told them Quyen's X-rays and lab tests were normal and there was nothing to worry about.

One of Quyen's neighbours eventually called the local social services agency, suggesting that they investigate the family for possible child neglect. After speaking to a number of the neighbours, the young social service worker was also concerned. He went to interview Quyen's daughter's teacher. At first, the teacher reported that there did not seem to be anything wrong; the girl was very quiet, and her teacher thought she might be naturally shy or deferential, as so many Orientals were apt to be. As she talked with the social worker, though, the teacher did begin to wonder whether the behaviour which she had attributed to culture might be something else. Instead of deference, it might be apathy. And the apathy might, as the worker suggested, be due to emotional or even to physical neglect.

When the worker visited their home, Quyen could tell that he disapproved. She knew the house was not as clean as it might be but, even if she had been able to speak to the young man, she would not have told him that she often could not bring herself to cook and clean these days. She tried not to cry when any of her family were at home because she didn't want to be a burden; but she kept thinking about her brother and how lonely she was. She often could not stop the tears.

The evidence against Quyen and Bang was soon so convincing that there seemed little choice but to take the children into protective custody. When he realized how poor the timing was, the social worker was chagrined. Had he known, he would have tried to delay the apprehension so that it did not take place on the Vietnamese New Year, an event for which Bang had specially taken time off from work.

With the children gone, Quyen's condition deteriorated. When Bang told the general practitioner who had examined her earlier that his wife was now talking about killing herself, the doctor arranged to have her transferred to the psychiatric hospital at the University of British Columbia.

Bang is perplexed and, when pressed, will admit he is angry too. He was told that, unlike Vietnam, Canada has many agencies that help people. He has now had experiences with social services, the schools, family doctors and psychiatrists. He feels that, as a result of their "help," he has lost his wife and children.

Quyen and Bang's story has been altered to protect their identities, but it is not exaggerated. Each of the Task Force members knows of families like them, and the written and oral testimonies contain descriptions of more.

As a caring society, Canada has responsibilities for newcomers like Quyen and Bang. These responsibilities include preventing emotional disorder, promoting well-being and ensuring that people who need treatment have access to it.

Migration creates a risk for one's mental health. However, instead of becoming mental health casualties, most immigrants and refugees succeed in becoming productive and valued members of Canadian society.

The Task Force attempted to identify the forces which increase the risk and create distress for new settlers, robbing Canada of their potential contributions. Negative public attitudes, separation from family and community, inability to speak English or French, and failure to find employment are among the most powerful causes of emotional distress. Persons whose pre-migration experience has been traumatic, women from traditional cultures, adolescents and the elderly also are at high risk for experiencing difficulties during resettlement. Quyen's and Bang's tragedy illustrates the sad cost of misunderstanding, loneliness, and lack of opportunity on the mental health of people who are otherwise able and eager to become contributing members of Canadian society.

Attending to these risk factors can help transform migration from a situation of risk into one of opportunity. Changing attitudes so that Canadians come to value our commitment to cultural pluralism more than we currently do will benefit everyone. Strengthening communities is, from a mental health perspective, an effective preventive measure. We must make every effort to ensure that people are equipped with tools such as language which they need to participate fully in Canadian life.

No matter how effective the programs for preventing mental disorder and promoting positive health prove to be, mental illness will not be eradicated. There will always be a need for care, through formal mental health services and through agencies which, although organized for other purposes, make important contributions to the treatment and rehabilitation of the mentally ill.

Unfortunately, many immigrants and refugees encounter formidable obstacles in their search for care. Quyen's and Bang's story contains no villains: they were victims of misunderstanding, not malfeasance. The misunderstandings sprang in part from language but, even more importantly, from misperception based on cultural and historical difference. Had Quyen's neighbours and the social worker understood that in Vietnam, it is perfectly appropriate to leave a young child in the care of an older sibling, and that crossing a street alone hardly seems dangerous to a girl who has grown up in a Thai refugee camp, they might have been less hasty in judging these actions as evidence of child neglect. Had Quyen's physician been able to communicate with her through someone other than a nine-year-old child, and had he understood that people from her culture are unlikely to spontaneously report feelings of emotional upset, he might have arrived at his diagnosis of depression earlier. Appropriate treatment, offered in a culturally sensitive manner, might have helped change this unfortunate story at several critical stages.

Removing barriers to access and making services more effective will call for a creative response by all levels of government, the mental health professions, and training centres. To meet the need for service, it will not be necessary to create something new for each language and cultural group in Canada. With the encouragement and leadership of the federal government, each province can provide cross-culturally effective mental health services using existing resources and a minimum of new dollars.

Three important principles, derived from the Task Force's findings and deliberations, underlie its recommendations:

- The mental health issues affecting immigrants and refugees include both issues of cause and issues of cure. To meet the mental health needs of Canada's migrants, risk-inducing factors must be mitigated and remedial services made universally accessible.

- The steps required to prevent and treat emotional distress in immigrants involve the persons with whom migrants come into contact as much as they do the migrants themselves. Sensitizing Canadian-born persons — immigration officers, settlement workers, teachers, neighbours and mental health personnel — to the ways in which culture can affect encounters between themselves and newcomers to this country can help eliminate major sources of distress for migrants and facilitate effective mental health care.

- The Task Force recommendations reflect the fact that no single governmental body or level of government is or can be responsible for the mental health of Canada's immigrants and refugees. For newcomers to adapt to and integrate with Canadian society, their strengths, needs and perspectives must be taken into account by decision-making bodies at each level of government, by planners and by service providers.

On the basis of these principles, and in consideration of the relative urgency, practicality, and feasibility of each proposed action, the **Task Force recommends that:**

1. CEIC develop a multilingual series of pre-migration orientation programs in collaboration with immigrant service agencies and ethno-cultural organizations for dissemination in refugee camps and at Canadian embassies abroad (Chapter 2, p.22).

2. CEIC expedite changes in admission criteria to accommodate a broader definition of family, and changes in admission procedure to accelerate the process of family reunification (Chapter 2, p.21).

3. CEIC, Health and Welfare and Secretary of State provide core funding to immigrant service agencies to guarantee their maintenance on a long-term basis (Chapter 2, p.21).

4. Health and Welfare and Secretary of State encourage and support the development of seniors' groups and programs in immigrant service agencies, general community service agencies, and ethno-cultural organizations (Chapter 11, p. 81).

5. Health and Welfare, Secretary of State, and Status of Women Canada develop and provide multilingual educational materials on women's rights and roles in Canada for discussion at immigrant service agencies, general community service agencies and ethno-cultural organizations (Chapter 10, p.76).

6. Health and Welfare and Secretary of State work with their provincial counterparts to ensure that the curricula and environments of schools, pre-schools and daycare facilities reflect the cultural diversity of the children attending them (Chapter 9, p.70).

7. Secretary of State, in cooperation with provincial ministries of education, encourage and support boards of education to adopt multicultural race relations policies similar to those that have already proven successful in Canada (Chapter 1, p.14).

8. CEIC, Ministry of Communications, and Secretary of State increase public education regarding the benefits of cultural pluralism, the contributions of immigrants to Canadian society, the difficulties faced by newcomers, and the effects of prejudice on both victim and perpetrator (Chapter 1, p.14).

9. CEIC enable all immigrants and refugees to have equal access to official language education whether or not they are destined for the labour market. Basic training allowances must be available regardless of the immigration class of training applicants (Chapter 3, p.28).

10. CEIC, in coordination with Secretary of State, expand and ensure the flexibility of official language training programs with respect to the level of mastery assumed, objectives of course content, duration of program, scheduling of instructional hours, and location of classes (Chapter 3, p.28).

11. CEIC, Ministry of Labour and Secretary of State enter into negotiations with their provincial counterparts to provide criteria and guidelines for entry into professions and trades by persons trained outside of Canada (Chapter 4, p.34).

12. Health and Welfare establish a national advisory body to coordinate and monitor social, health and mental health services to ethnic minorities, with participation from professional associations, service administration, and immigrant service agencies (Chapter 6, p.52).

13. Health and Welfare invite requests for proposals on the development of cross-cultural training modules in education, family practice, nursing, psychiatry, psychology and social work (Chapter 7, p.57).

14. Health and Welfare, Secretary of State and their provincial counterparts encourage institutions of higher learning to identify cross-cultural education as a priority, particularly for students of education, medicine, nursing, psychiatry, psychology and social work (Chapter 7, p.57).

15. Health and Welfare and Secretary of State encourage all funders of social and health services to require that organizations applying for funds provide evidence of efforts to make their services to ethnic minorities accessible and to provide evaluations of their effectiveness (Chapter 6, p.52).

16. Health and Welfare identify immigrants and refugees as well as multicultural concerns among its priority areas for Health Promotion contributions, research and National Welfare grants, and other funded activities (Chapter 6, p.52).

17. Health and Welfare, in collaboration with immigrant service agencies and ethno-cultural organizations, develop multilingual educational materials on the psychological consequences of migration and the resources for mental health care. Health and Welfare should provide these materials to provincial ministries of health and immigrant service agencies for dissemination through front-line service providers and ethnic media
(Chapter 5, p.45).

18. Health and Welfare and its provincial counterparts encourage all social, health and mental health service agencies to increase their hiring of ethnic minority staff through the adoption of equal employment opportunity policies (Chapter 8, p.62).

19. Health and Welfare and Secretary of State encourage the admissions committees of social, health and mental health service training programs to recognize as assets, fluency in a non-official language and intention to work with clients who speak that language (Chapter 8, p.62).

20. Health and Welfare encourage provincial mental health services to employ mental health practitioners at major immigrant service agencies (Chapter 5, p.46).

21. Health and Welfare, in collaboration with provincial ministries of health and immigrant service agencies, develop a curriculum for training interpreters used by mental health services. Immigrant service agencies and provincial ministries of health should be provided with this curriculum for use in classes supported by Health and Welfare (Chapter 5, p.46).

22. Health and Welfare support research and health promotion initiatives to delineate the psychological consequences of torture and to develop effective treatment modalities for survivors of torture and their families (Chapter 12, p.86).

23. Health and Welfare encourage provincial mental health services to give special consideration to the funding of ethno-specific rehabilitation and reintegration facilities (Chapter 5, p.46).

In recommending that the above actions be taken, the Task Force emphasizes that the cost-effectiveness of any given action depends heavily on the knowledge and experience on which it is based.

The need for accurate, empirical research is consistently noted throughout this report. Policy changes regarding, for example, family reunification criteria or professional accreditation guidelines require detailed research before decisions can be made. Effective education programs, whether directed towards the Canadian-born public or to immigrants from various cultural backgrounds, must be based on sound information regarding existing attitudes, beliefs and needs.

Above all, the development of both preventive and remedial services such as seniors' support groups or mental health rehabilitation services must reflect a comprehensive understanding of the needs, strengths and cultural perspectives of the individuals involved.

Implementation of the recommended policies, programs and services also depends on controlled pilot testing and evaluation. If an institution of higher education prioritizes cross-cultural content for students of the helping professions, the means chosen should be measured for their effectiveness. A curriculum designed to train paraprofessional interpreters for work with mental health practitioners should be implemented on an experimental basis and its effectiveness assessed. Remedial services for victims of catastrophic stress and their families must be tested and evaluated before being implemented on a large scale.

To maximize the benefits of the research and evaluations, their findings should be made available to individuals, community organizations and government bodies that can use them. At present, results of research concerning immigrants tend to be published either in professional medical journals to which few immigrant service providers subscribe, or in culturally oriented works to which only "converted" mental health practitioners refer. Evaluations of policies and programs affecting immigrants tend to remain internal documents for the eyes of program planners and funders alone. Both these situations need to change before the evaluations and research conducted can be considered truly cost-effective.

Given the need for empirical research, controlled experimentation, and the coordinated dissemination of findings, the Task Force calls for a four-step strategy, summarized in four additional recommendations, to ensure the successful implementation of its recommendations.

24. **CEIC, Health and Welfare and Secretary of State establish across Canada at least three centres of excellence for research on issues affecting immigrant mental health.** These centres would be dedicated to designing and carrying out empirical studies on topics such as the effects of negative attitudes on mental health; the mental health of migrant children, women, the elderly and victims of catastrophic stress; and how culture affects the assessment, treatment and rehabilitation of the mentally ill.

    In addition, these centres would be involved in the evaluation of new models of care. Each centre should receive assured funding for at least five interdisciplinary core staff, four postdoctoral fellowships, and two predoctoral scholarships. Immigrants and refugees and members of newer ethnic groups in Canada should be recruited for a significant number of the staff and training positions.

    Funding should be provided for pilot research projects. For large-scale inquiries, the centres should apply for funding through regular channels.

25. **CEIC, Health and Welfare and Secretary of State establish across Canada at least three centres of excellence for cross-cultural training.** In addition to training students and practitioners in the social and health service professions, these centres would provide training for persons who must in turn educate others who come into contact with immigrants: employment counsellors, second language instructors, and lawyers. The centres would also conduct periodic surveys to determine how cultural awareness is being introduced in mental health training programs in Canada and how this determines qualifications for licensure and practice.

    Funding should enable these centres to offer training fellowships to individuals from a wide range of disciplines and occupations and from immigrant, refugee and newer ethnic groups in Canada. Seed funding should also be provided to enable these centres to develop pilot projects to test innovative models of service delivery and new research and demonstration projects. For more definitive studies, the centres should apply through the regular funding channels.

26. **CEIC, Health and Welfare and Secretary of State establish a single, computerized information centre to collect, coordinate and disseminate the results of research and evaluations as well as descriptions of service and training programs directed to migrants and ethnic minorities in Canada.** Information would be gathered from, and made available to government departments, professional associations, general community and immigrant service agencies, academic institutions and ethnic organizations. Ideally, funding should provide not only for the specific sources

of information to be made known but also for authorized abstracts of the research findings and evaluations to be disseminated.

27. **Health and Welfare and Secretary of State create a national body to advise on and monitor the implementation of the Task Force recommendations.**

Government, service providers, planners and research workers are constantly being encouraged to make preventive programs and treatment services more culturally sensitive and appropriate. Although information exists on which programs could be built, large gaps in knowledge and experience remain. Until these gaps are bridged, all the goodwill in the world will not be sufficient to address the concerns presented to the Task Force. As the Director of Out-Patient Services, Camp Hill Hospital, Halifax expressed it:

> *I am left with the feeling, which I can't substantiate, that the problem is greater in this area than we imagine. At this point, however, I find it difficult to envisage any way to adapt present services to better deal with the problem. (Submission: Teehan)*

Coordination of effort — in which findings emanating from the research centres can be translated into program models, which can be tested in the service and training centres, and the results disseminated through the information centre — would help in overcoming gaps in knowledge and facilitate the transmission of new knowledge to service and training programs.

Implementation of the Task Force's recommendations will serve our long-term national goal to promote the health of all. Equally important, the recommendations and the concerns out of which they arise are a challenge to our national will. In just under 50 years, Canada has evolved from a nation whose indifference to the suffering of others remains as a permanent blot on our history (Malarek, 1988; Abella and Troper, 1982) to one universally admired for its humanitarianism. Although we now open our doors more easily than in the past, we do not yet accord newcomers an adequate welcome. The late anthropologist and philosopher Margaret Mead stated that one could judge the quality of a society by the way it treats its most vulnerable members.

Persons troubled by mental health problems, feeling they have nowhere to turn for help, are vulnerable people. Our response to their need is a test of this nation's moral strength.

Appendix one

Glossary of Terms

Assimilation

Clearly distinct from integration, a process of eliminating distinctive group characteristics which may be encouraged as a formal policy (e.g., American "melting pot").

Attitude

A set of evaluations (positive or negative) about members of a social category. These evaluations serve as predispositions to act for or against members of these categories, and may erupt as behaviours.

Convention refugee

One of three classes of admissible immigrants under the 1976 *Immigration Act.* Includes anyone who fits the United Nations definition: "any person who, by reason of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group or political opinion, (a) is outside the country of his nationality and is unable or, by reason of such fear, is unwilling to avail himself of the protection of that country, or, (b) not having a country of nationality, is outside the country of his former habitual residence and is unable, or by reason of such fear, is unwilling to return to that country."

Discrimination

An act, for or against, a member of a social category. These acts of discrimination may or may not be a consequence of an attitude or prejudice. Acts always need to be judged against some external criterion (such as acts directed toward other social categories) in order to show discrimination.

Ethnic Group

A social group with a shared cultural heritage which maintains distinctive cultural (linguistic, religious, etc.) traditions while living within a larger (usually multicultural) society. A sense of collective identity and some co-residence and co-marriage usually characterizes an ethnic group. In principle, all residents of Canada are members of one or more ethnic groups.

Ethno-Specific

Pertaining to a single ethnic group.

Family Class

One of three classes of admissible immigrants under the 1976 ***Immigration Act***, formed of close relatives of a sponsor in Canada. Includes the sponsor's spouse, unmarried children under age 21, parents and grandparents.

Ghettoization

Isolation of members of ethnic groups within their ethno-specific community.

Heritage Culture

The intellectual development of an ethnic group in Canada.

Heritage Languages

A language associated with an ethnic group in Canada, other than the country's official languages.

Integration

A process, clearly distinct from assimilation, by which groups and/or individuals become able to participate fully in the political, economic, social and cultural life of the country.

Immigrant

A person who seeks lawful permission to come to Canada to establish permanent residence.

Larger Society

The social, political, economic and educational institutions that are shared by the general population and provide the context within which ethnic, racial and minority groups live.

Mainstream

A term which defies Canada's image of a multicultural society where all cultures have equal status and none more power than others. Replaced in this report by "public," "general community" and "established."

Marginalization

The process that people who cannot speak the majority culture's language or find work, undergo as they are cut off from customary sources of social support and do not participate fully in society.

Mental Health

Both mental disorder and positive mental health.

Mental Health Care System

Formal care offered by hospitals, clinics and private practitioners as well as informal services provided in physicians' offices, schools, second language classrooms, immigrant service agencies and other facilities.

Migrant

At times, we use "migrant" or "immigrant" in this report to cover persons in all categories: family class, refugees, designated class and independent immigrants. The term does not, however, include foreign students or temporary workers, people who were not included in the Task Force's mandate.

Minority Group

Any group that lacks power in society due to ethnicity, race, size of population, wealth, sex, handicap, intellect and/or other factors. Ethnic and racial groups may or may not be minority groups, depending on their power in society.

Multicultural

Describes the institutions that serve the larger society. In some cases, ethno-specific institutions exist as alternatives to both multicultural institutions and those in the larger society.

Multiculturalism

The official ideology of cultural pluralism, where all cultures have equal status and merit in Canadian society, and none has more power than another. Multiculturalism policies promote integration, not assimilation, of minority groups into society.

Official Languages

In Canada, English and French share official language status nationally. Only one language has official status in the provinces and territories, except for New Brunswick where both languages have official status.

Outreach

Programs designed to increase the awareness of the general public and/or specific client groups concerning the facilities and services provided by an organization, or to increase their participation.

Prejudice

A mental state or attitude of pre-judging (generally unfavourably), attributing to that person characteristics which are attributed to a group of which the person is a member. Types of prejudice include: Ethnocentrism — toward members of ethnic or cultural groups, usually not one's own; Racism — toward members of racial groups, usually not one's own. Sexism, Regionalism, Fanatacism, Ageism, Classism are similarly defined by gender, region, religion, age and social class groups.

Racial Group

A group with common biological heritage, usually one that makes them visibly distinctive from others in their milieu. If there is a shared sense of membership and identity, then racial groups are merely categories created by others on the basis of superficial physical characteristics.

Racism

SEE Prejudice.

Refugee

SEE Convention Refugee.

Refugee Claimant

A person who appears on Canadian soil and claims refugee status under the Geneva Convention.

Settlement Programs

Programs designed to assist newly arriving immigrants to integrate into a society. Typically they would include language, orientation, housing and counselling services.

Stereotype

Beliefs held by individuals about the presumed physical and psychological characteristics of members of a social category. These beliefs can be either positive or negative. When applied so generally that individual differences are not recognized, or even defined, they are considered impediments to quality human relations.

Stress

Resulting from a situation or experience which overwhelms the individual's typical ways of coping and which usually results in a reaction, either physical or psychological, or both.

Underemployment

Work that does not fully use a person's abilities, especially when the work is not in the trade or profession for which they were trained.

Appendix two

Written Submissions

ACCESS Committee of Ottawa-Carleton
Ottawa, Ontario

Alberta Association of Immigrant Serving Agencies (A.A.I.S.A.)
Edmonton, Alberta

Alberta Immigration and Settlement Services, Department of Career Development and Employment
Edmonton, Alberta

Alberta Mental Health Services — Edmonton Region, Department of Community and Occupational Health
Edmonton, Alberta

Alberta/NWT Network of Immigrant Women
Calgary Alberta

AMALC (Association Médicale pour l'Amérique Latine et les Caraîbes)
Verdun, Québec

Association for New Canadians
St. John's Newfoundland

Association of Neighbourhood Houses of Greater Vancouver
Vancouver, B.C.

British Columbia. Association of Society
Calgary, Alberta

Calgary Catholic Immigration Society
Calgary, Alberta

Calgary Immigrant Aid Society
Calgary, Alberta

Canadian-African Newcomer Aid Centre of Toronto (C.A.N.A.C.T.)
Toronto, Ontario

Capital Mental Health Association
Victoria, B.C.

Catholic Immigration Bureau,
Archdiocese of Toronto
Toronto, Ontario

Catholic Immigration Centre
Ottawa, Ontario

Catholic Social Services
Immigration and Settlement Service
Edmonton, Alberta

Centre for Research and Education
in Human Services and Kitchener-Waterloo
Refugee Co-ordinating Committee
Kitchener, Ontario

Centre Maghrebin de Recherche
et d'Information (CMRI)
Montréal, Québec

Centre Portugais de Référence et Promotion Sociale
Montréal, Québec

Changing Together —
A Centre for Immigrant Women
Edmonton, Alberta

Clarke Institute of Psychiatry, Social And
Community Psychiatry
Toronto, Ontario

CLSC Côte-des-Neiges
Montréal, Québec

Coalition for Immigrant Women in Nova Scotia
(CIWINS)
Halifax, Nova Scotia

Community Resources Consultants of Toronto
Toronto, Ontario

COSTI- IIAS Immigrant Services,
Family Counselling Centre
Toronto, Ontario

Department of Counselling Psychology
University of British Columbia
Vancouver, B.C.

Edmonton Board of Health
Edmonton, Alberta

Edmonton Immigrant Services Association
Edmonton, Alberta

Eritrean Community in Winnipeg, Inc.
Winnipeg, Manitoba

ESL Reception and Assessment Centre
Edmonton Public Schools
Edmonton, Alberta

Family Service Association of Metropolitan Toronto
Toronto, Ontario

Greater Vancouver Mental Health Service Society
Vancouver, B.C

Guelph and District Multicultural Centre, Inc.
Guelph, Ontario

Guzder, Jaswant
Montréal, Québec

Hanifa, Subaida B.
Waterloo, Ontario

Harambee Centres Canada, Toronto Chapter
Toronto, Ontario

Herberg, Dorothy C. and Edward N. Herberg
Toronto, Ontario

Hispanic Council of Metropolitan Toronto
Toronto, Ontario

Hong Fook Mental Health Association
Toronto, Ontario

Hrycak, Nina
Calgary, Alberta

Immigrant Women's Association of Manitoba, Inc.
Winnipeg, Manitoba

Immigrant Women's Group of P.E.I.
Charlottetown, P.E.I.

Inland Refugee Society of British Columbia
Vancouver, B.C.

Inter-Church Committee for Refugees/
Comité Inter-Églises pour les Réfugiés
Toronto, Ontario

Inter-Cultural Association of Greater Victoria
Victoria, B.C.

Intercultural Task Force
Halifax, Nova Scotia

Jamaican-Canadian Association
Toronto, Ontario

Japanese Community Volunteers' Association
Vancouver, B.C.

Kingston and District Immigrant Services
Kingston, Ontario

Kristl, Jiri
Port Coquitlam, B.C.

Kurol, Vilma
Saint John, N.B.

Legal Assistance of Windsor
Windsor, Ontario

Lo, Hung-Tat
Toronto, Ontario

London Cross Cultural Learner Centre
Immigrant Seniors Project
London, Ontario

Medicine Hat Society for Immigrant Settlement
Medicine Hat, Alberta

Mensah, Lynette
Halifax, Nova Scotia

Metro Toronto Multicultural Mental Health
Group, Toronto Department of Public Health
Northern Health Area
Toronto, Ontario

Metropolitan Immigrant Settlement Association
Halifax, Nova Scotia

Montgomery, Randal
Vancouver, B.C.

M.O.S.A.I.C.
Vancouver, B.C.

Multicultural Health Coalition
Downsview, Ontario

National Association of Canadians of Origins
in India (NACOI), Montréal Chapter
Montréal, Québec

New Brunswick Multicultural Council
Fredericton, New Brunswick

Newfoundland and Labrador
Department of Social Services
St. John's, Newfoundland

Nova Scotia Hospital
Dartmouth, Nova Scotia

O.A.S.I.S. (Orientation Adjustment Services
for Immigrants Society)
Vancouver, B.C.

Ontario Welcome House
Toronto, Ontario

Pacific Immigrant Resources Society, Preschool
Multicultural Services and Vancouver Health
Department
Vancouver , B.C.

Parkdale Community Legal Services Inc.
Toronto, Ontario

Portuguese Interagency Network (P.I.N.)
Toronto, Ontario

Preschool Multicultural Services, Vancouver Health
Department and Pacific Immigrant Resources Society
Vancouver, B.C.

S.E.A.R.C.O.M. (South East Asian Refugee
Community Organization of Manitoba, Inc.)
Winnipeg, Manitoba

S.U.C.C.E.S.S. (The United Chinese Community
Enrichment Services Society)
Vancouver, B.C.

Saskatchewan Health
Mental Health Services Branch
Regina, Saskatchewan

Saskatoon Open Door Society
Saskatoon, Saskatchewan

Sauve, Virginia
Edmonton, Alberta

South East Asian Service (S.E.A.S.) Centre
Toronto, Ontario

St. Barnabas Refugee Society
Edmonton, Alberta

Student Services and Counselling
Mount Saint Vincent University
Halifax, Nova Scotia

Surrey Delta Immigrant Services Society
Surrey, B.C.

Surrey School District 36
Surrey, B.C.

Sztopa, Emil
Vancouver, B.C.

Table de Concertation des Organismes
de Montréal au Service des Réfugiés
Montréal, Québec

Teehan M.D.
Halifax, Nova Scotia

Thompson, Pamela R.
Ottawa, Ontario

Toronto Board of Education
Toronto, Ontario

Toronto Department of Public Health
Toronto, Ontario

Ujimoto, K. Victor
Guelph, Ontario

United Church of Canada, British Columbia
Conference, Division of Global Concerns
Vancouver, B.C.

United Nations High Commissioner for Refugees
Ottawa, Ontario

University of Toronto, Department of Psychiatry
Division of Child and Adolescent Psychiatry
Toronto, Ontario

Vancouver Health Department, East Office
Vancouver, B.C.

Vancouver Health Department
Pacific Immigrant Resources Society
and Preschool Multicultural Services
Vancouver, B.C.

Vancouver Health Department, South Office
Vancouver, B.C.

Woodgreen Red Door Family Shelter, Refugee
Referral Office and Refugee Housing Unit
Toronto, Ontario

Working Women Community Centre
Toronto, Ontario

Appendix three

Oral Presentations

Vancouver Public Hearing
April 10–11, 1987

Alberta Association of Immigrant Serving Agencies
(A.A.I.S.A.)
Edmonton, Alberta

Association of Neighbourhood Houses
of Greater Vancouver
Vancouver, B.C.

Calgary Catholic Immigration Society
Calgary, Alberta

Department of Counselling Psychology
University of British Columbia
Vancouver, B.C.

E.S.L. Reception and Assessment Centre
Edmonton Public Schools
Edmonton, Alberta

Edmonton Board of Health
Edmonton, Alberta

Eritrean Community in Winnipeg, Inc.
Winnipeg, Manitoba

Intercultural Association of Greater Victoria
Victoria, B.C.

Japanese Community Volunteers Association
(Tonari Gumi)
Vancouver, B.C.

M.O.S.A.I.C. (Multilingual Orientation Service
Association for Immigrant Communities)
Vancouver, B.C.

O.A.S.I.S. (Orientation Adjustment Services for Immigrants Society)
Vancouver, B.C.

Pacific Immigrant Resources Society (P.I.R.S.)
Vancouver Health Department South Office
and Preschool Multicultural Services
Vancouver, B.C.

Preschool Multicultural Services
Pacific Immigrant Resources Society (P.I.R.S.)
and Vancouver Health Department, South Office
Vancouver, B.C.

S.E.A.R.C.O.M. (Southeast Asian Refugee Community Organization of Manitoba, Inc.)
Winnipeg, Manitoba

S.U.C.C.E.S.S. (United Chinese Community Enrichment Services Society)
Vancouver, B.C.

St. Barnabas Refugee Society
Edmonton, Alberta

Salvadorean Canadian Cultural Centre
Winnipeg, Manitoba

Sauvé, Virginia
Edmonton, Alberta

Vancouver Health Department, South Office
Preschool Multicultural Services
and Pacific Immigrant Resources Society (P.I.R.S.)
Vancouver, B.C.

Vancouver Society on Immigrant Women
Vancouver, B.C.

Toronto Public Hearing
May 6–7, 1987

COSTI - IIAS
Immigrant Services, Family Counselling Centre
Toronto, Ontario

Canadian-African Newcomer Aid Centre of Toronto (C.A.N.A.C.T.)
Toronto, Ontario

Catholic Immigration Bureau
Toronto, Ontario

Centre for Research and Education in Human Services; and Kitchener-Waterloo Refugee Co-ordinating Committee
Kitchener, Ontario

Herberg, Dorothy; and Edward Herberg
Mississauga, Ontario

Hispanic Social Development Council
of Metropolitan Toronto
Toronto, Ontario

Hong Fook Mental Health Association
Toronto, Ontario

Intercede
Toronto, Ontario

Interchurch Committee for Refugees
Toronto, Ontario

London Cross Cultural Learner Centre
Immigrant Senior Project
London, Ontario

Metro Toronto Multicultural Mental Health Group, Toronto Department of Public Health
Northern Health Area
Toronto, Ontario

Multicultural Health Coalition
Downsview, Ontario

New Experiences for Refugee Women
Toronto, Ontario

Ontario Welcome House
Toronto, Ontario

Parkdale Community Legal Services Inc.
Toronto, Ontario

Portuguese Interagency Network
Toronto, Ontario

Social Planning Council of Metro Toronto
Toronto, Ontario

Ujimoto, K. Victor
Guelph, Ontario

Working Women Community Centre
Toronto, Ontario

Woodgreen Red Door Family Shelter, Refugee
Referral Office and Refugee Housing Unit
Toronto, Ontario

Montreal Public Hearings
May 8–9, 1987

Association for New Canadians
St. John's Newfoundland

Association médicale pour l'Amérique Latine
et les Caraîbes (AMALC)
Verdun, Québec

CLSC Côte-des-Neiges
Montréal, Québec

Catholic Immigration Centre/
Centre Catholique pour Immigrants
Ottawa, Ontario

Centre Maghrebin de Recherche et d'Information
(CMRI)
Montréal, Québec

Centre portugais de référence et promotion sociale
Montréal, Québec

Guzder, Jaswant
Montréal, Québec

Immigrant Women's Group of P.E.I.
Charlottetown, P.E.I.

Intercultural Task Force
Halifax, Nova Scotia

Mensah, Lynette
Halifax, Nova Scotia

Metropolitan Immigrant Settlement Association
Halifax, Nova Scotia

National Association of Canadians of Origins in
India/ Association nationale des canadiens/nes
d'origine indienne, Montréal Chapter
Montréal, Québec

New Brunswick Multicultural Council/Conseil
multiculturel du Nouveau-Brunswick
Fredericton, New Brunswick

Services des interprètes auprès des réfugiés indochinois (SIARI); and Table de concertation des organismes de Montréal au service des réfugiés/ées
Montréal, Québec

Table de concertation des organismes de Montréal
au service des réfugiés; and Services des interprètes
auprès des réfugiés indochinois (SIARI)
Montréal, Québec

United Nations High Commissioner for Refugees
(UNCHR) , Branch Office in Canada
Ottawa, Ontario

Appendix four

Additional Consultations

Adelman, Professor Howard
Toronto, Ontario

Alberta Department of Career Development
and Employment

Alberta Department of Hospitals and Medical Care

Alberta Department of Community
and Occupational Health

Allodi, Dr. Federico A.
Toronto, Ontario

AMSSA (Affiliation of Multicultural Societies
& Service Agencies of B.C.)
Vancouver, B.C.

Association Multi-Ethnique pour intégration des
Personnes Handicapées du Québec
Montréal, Québec

Atkey, Mr. Ronald G., P.C., Q.C.
Toronto, Ontario

British Columbia Forensic Psychiatric Services
Ministry of Health
Burnaby, B.C.

CLSC Côte-des-Neiges
Montréal, Québec

Canadian Centre for the Rehabilitation
of Victims of Torture
Toronto, Ontario

Canadian Mental Health Association, B.C. Division
Vancouver, B.C.

Children's Aid Society of Metro Toronto
Toronto, Ontario

Dartmouth Immigrant Orientation Association
Dartmouth, Nova Scotia

Disman, Dr. Milada
Toronto, Ontario

Immigrant Access Services
Winnipeg, Manitoba

Kumar-Misir, Dr. Victor
Scarborough, Ontario

Lomas, Mr. Peter
Vancouver, B.C.

Lovink, Mr. Tony
Ottawa, Ontario

Malarek, Mr. Victor
Toronto, Ontario

Mangalam, Professor J.J.
Halifax, Nova Scotia

Manitoba Department of Community Services

Manitoba Department of Employment Services
and Economic Security

Manitoba Department of Health

New Brunswick Department of Health
and Community Services

New Brunswick Department of Income Assistance

Ontario Ministry of Health

Ontario Ministry of Citizenship and Culture

Ontario Ministry of Community
and Social Services

Ontario Ministry of the Attorney General

P.E.I. Multicultural Council
Charlottetown, P.E.I.

Psychologists Association of Alberta
Edmonton, Alberta

Québec. Direction des Communautés Culturelles
et de l'Immigration

Québec. Ministère de la Santé
et des Services Sociaux

S.I.A.R.I. (Services des Interprètes
Auprès des Réfugiés Indochinois)
Montréal, Québec

Saskatchewan Department of Health

Social and Educational Studies
Faculty of Education
University of British Columbia
Vancouver, B.C.

Standing Conference of Canadian Organizations
Concerned for Refugees

Survivors International Canada
Toronto, Ontario

Toronto Office Skills Training Project
Toronto, Ontario

Tuzi, Ms. Marisa
Vancouver, B.C.

Vancouver Association for the Survivors of Torture
Vancouver, B.C.

Vancouver Refugee Council
Vancouver, B.C.

Appendix five

Works Cited

Abella, Irving and Harold Troper. **None is Too Many: Canada and the Jews of Europe 1933–1948**. Toronto: Lester & Orpen Dennys, c1982, xiii, 336 p.

Agard, R. **Access to the Social Assistance Delivery Systems by Various Ethnocultural Groups**. n.p.: Social Assistance Review, 1987.

Balaran, Paul. **Refugees and Migrants: Problems and Program Responses: A Look at the Causes and Consequences of Today's Major International Population Flows, and at the Ford Foundation's New Programs to Address the Problems of Refugees and Migrants in the United States and Elsewhere in the World**. New York: Ford Foundations, 1983, 64 p.

Beiser, M., P.J. Johnson and R.C. Nann, ed. **Refugee Resettlement Project**. Vancouver: The Refugee Resettlement Project, University of British Columbia, 1984.

Beiser, M., R.J. Turner and S. Ganesan. **Catastrophic Stress and Factors Affecting Its Consequences Among Southeast Asian Refugees.**

Bernstein, B. "A Critique of the Concept Compensatory Education". **In Functions of Language in the Classroom.** Ed. by C.B. Cazden, V. John and D. Hymes. New York: Teachers College Press, 1972.

Berry, John W., et al. **Multiculturalism and Ethnic Attitudes in Canada.** Ottawa: Supply and Services Canada, 1977, 359 p.
Published also in French under the title: **Attitudes à l'égard du multiculturalisme et des groupes ethniques au Canada.**

Canada. **The Constitution Act, 1982/La loi constitutionnelle de 1982.** Ottawa: Queen's Printer/Imprimeur de la Reine, c1982, 23 p.

Canada. **Immigration Act, 1976/Loi de 1976 sur l'immigration.** Ottawa: Queen's Printer/Imprimeur de la reine, 1985. 1 v.

Canada. Dept. of Justice. **Toward Equality: The Response to the Report of the Parliamentary Committee on Equality Rights/Cap sur l'égalité: réponse au rapport du Comité parlementaire sur les droits à l'égalité.** Ottawa: Communications and Public Affairs, Dept. of Justice/Communications et affaires publiques, Ministère de la justice, c1986, 69, 69 p.

Canada. Employment and Immigration Canada (Dept.). **Battered Immigrants and Immigration Status.** Ottawa: 1986.

Canada. Parliament. House of Commons. Special Committee on Participation of Visible Minorities in Canadian Society. **Equality Now: Report of the Special Committee on Participation of Visible Minorities in Canadian Society.** Ottawa: 1984, ix, 166 p.

Canada. Royal Commission on Equality in Employment. **Report of the Commission on Equality in Employment.** Rosalie Silberman Abella. Ottawa: Supply and Services Canada, 1984, viii, 393 p.

Council of Interracial Books for Children. "Childcare Shapes the Future: Racism: Related Problems, Research and Strategies." In **Interracial Books for Children Bulletin.** V.14, no. 7–8, 1983, p. 6–14.

Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees. **Review of the Literature on Migrant Mental Health.** Vancouver: 1986.

Canadian Human Rights Commission — **Annual Report/Rapport annuel.** Ottawa: 1986, 33, 33 p.

Disman, M. **Aging and Ethnicity in Ontario.** Toronto: n.p., 1986.

Doyle, Robert. **Access to Health and Social Services for Members of Diverse Cultural and Racial Groups in Metropolitan Toronto.** Toronto: Social Planning Council of Metropolitan Toronto, 1987, 3 v.

Epp, Jake. **Achieving Health for All: A Framework for Health Promotion.** Ottawa: Health and Welfare Canada, c1986, 13 p. Published also in French under the title: **La santé pour tous: plan d'ensemble pour la promotion de la santé.**

Kitchener-Waterloo Council of Churches — **Bridging the Gap:Beyond Refugees' Material Needs.** Kitchener, Ont.: 1988.

Kurien, J. "Indo-Canadian: Our Modus Operandi and Our Institutions." In **Newsletter** (National Association of Canadians of Origins in India, Montreal Chapter). v.7, no. 1, 1987.

Malarek, Victor. **Haven's Gate: Canada's Immigration Fiasco.** Toronto: Macmillan of Canada, c1987, 262 p.

Moffic, H.S., et al. "Education in Cultural Psychiatry in the United States." In **Transcultural Psychiatric Research Review and Bulletin.** v.24, no. 3, 1987, p. 167–187.

Multiculturalism Act. n.p.: n.p., 1987.

Multiculturalism Policy. n.p.: n.p., 1971

Naipaul, V.S. **A Bend in the River.** New York: Vintage Books, 1980, c1979, 278 p.

One Child, Two Cultures: A Manual for Facilitating the Integration of Newcomer Children in Educational Settings. Winnipeg: Manitoba Dept. of Employment Services and Economic Security, Immigration and Settlement Branch, 1987, 251 p.

Ontario. Cabinet Committee on Race Relations. **Access to Trades and Professions in Ontario: Project Report.** Toronto: 1987, various paging.

Peters, R. **The Interagency Mental Health Council's Committee on Multiculturalism and Mental Health: Progress Update.** Vancouver: Greater Vancouver Mental Service Society, 1988.

Rae, Michael. **Multiculturalism, Racism, and the Classroom.** Toronto: Canadian Education Association, 1982, 68 p. Published also in French under the title: **Multiculturalisme et racisme à l'école.**

Sabatier, C. **The Mother and Her Infant: Cultural Variations**. n.p.: Département de psychologie, Université du Québec, n.d.

Scarry, Elaine. **The Body in Pain: The Making and Unmaking of the World**. New York: Oxford University Press, 1985, vii, 385 p.

Seydegart, Kasia and G. Spears. **Beyond Dialogue: Immigrant Women in Canada, 1985–1990**. n.p.: Erin Research, 1985, 114 l.

Sue, Stuntey. "Community Mental Health Services to Minority Groups: Some Optimism, Some Pessimism." In **American Psychologist**. v. 32, no 8, Aug. 1977, p. 616–625.

Task Force on the Child as Citizen. **Admittance Restricted: The Child as Citizen in Canada**. Ottawa: Canadian Council on Children and Youth, 1978, 172, 195 p. English, French.

Wiebe, Kathy. **Violence Against Immigrant Women and Children: An Overview for Community Workers**. Vancouver: Women Against Violence Against Women, Rape Crisis Center, 1985, 59 p.